London Health Sciences Centre

PAEDIATRIC PRE-OPERATIVE / PRE-PROCEDURAL PATIENT QUESTIONNAIRE

Instructions: Please read all questions carefully and respond by placing a check (✓) in the "yes" or "no" box. For a "yes" response provide additional information in the "describe" section, including the date the problem was diagnosed and any medications, treatments, or hospital stays your child has required for the problem.

	YES	NO	DESCRIBE
1. Does your child have congenital or other heart disease?			
2. Does your child have a heart murmur or heart valve problem?			
3. Has your child been treated for an irregular heart beat?			
4. Does your child have high blood pressure?			
5. Does your child have asthma?			☐ Use Inhalers Occasionally ☐ Use Inhalers Regularly ☐ On Prednisone
6. Does your child cough frequently, have bronchitis, tuberculosis, cystic fibrosis or other lung disease?			
7. Does your child smoke cigarettes or have exposure to second hand smoke?			
8. Does your child have sleep apnea?			
9. Does your child have liver disease, or a history of jaundice or hepatitis?			
10. Does your child drink alcohol?			
11. Does your child have indigestion, heartburn, or reflux?			
12. Does your child have a history of hormone/thyroid problems?			
13. Does your child have diabetes?			☐ Diet Controlled ☐ On Pills ☐ On Insulin
14. Is your child of African descent?			
15. Has your child ever been tested for **Sickle Cell Anemia**?			
16. Does your child have kidney/ urinary problems?			
17. Does your child have any problems with his/her muscles or joints?			
18. Does your child have any problems with his/her nervous system?			

Please turn over ☛

PAEDIATRIC PRE-OPERATIVE / PRE-PROCEDURAL PATIENT QUESTIONNAIRE (cont'd)

	YES	NO	DESCRIBE
19. Has your child had epilepsy, blackouts, seizures or a stroke?			
20. Has your child had low blood counts, blood clots, or excessive bleeding?			
21. Does your child have any health problems, not mentioned so far? (Such as developmental delay, behavioural, visual, hearing)			
22. Has your child ever had a general anesthetic? If yes, when was the last anesthetic?			
23. Has your child's health changed since the last anesthetic?			
24. Has anyone related to your child had a reaction to anaesthetic?			
25. Is there any family history of **Malignant Hyperthermia**?			
26 Does your child have neck or jaw pain or arthritis?			
27. Does your child wear a dental plate, braces, or have capped or loose teeth?			
28. If your child is of child bearing age, could she be pregnant?			
29. Has your child taken prednisone, steroid medication, or cortisone-like drugs in the past year?			
30. Would you refuse a blood transfusion as a life saving procedure for your child?			
31. Does your child have any mouth or body piercings?			

32. Please list any medication, food or other allergies (including latex) that your child may have:

33. Please list any **medications** (including inhalers and herbal supplements) your child is currently taking:

34. Please list any **operations** your child has had in the past:

35. If this is the day of surgery, when did your child last eat or drink?

36.* Age:_____ Weight:_____ (kg) Height:_____ (cm) **This question to be completed by hospital personnel.*

DATE: (YYYY/MM/DD) _____ **SIGNATURE:** _____

RELATIONSHIP TO PATIENT: ☐ Parent ☐ Guardian ☐ Self

DATE: (YYYY/MM/DD)_____ **REVIEWED BY:** _____