

**PREOPERATIVE PEDIATRIC QUESTIONNAIRE**

Name of Patient \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Sex M / F

Home # \_\_\_\_\_ Alternate# \_\_\_\_\_

Name of person taking child home \_\_\_\_\_

List of allergies \_\_\_\_\_

List all medications \_\_\_\_\_

List all previous surgeries \_\_\_\_\_

Birth History: Yes No

Was child born prematurely? \_\_\_\_\_

Birth Wt. \_\_\_\_\_

Cesarean Section? \_\_\_\_\_

Any problems at birth? \_\_\_\_\_

Does your child smoke? \_\_\_\_\_

If yes, how much? \_\_\_\_\_

Does your child drink alcohol, smoke marijuana or use illegal drugs? \_\_\_\_\_

Has your child or any blood relatives ever had a serious complication related to anesthesia? \_\_\_\_\_

Are immunizations up to date? \_\_\_\_\_

Loose teeth, Chipped teeth or Braces? \_\_\_\_\_

Previous Overnight Hospitalizations: Reason \_\_\_\_\_

Does your child have any of the following conditions?

	Yes	No	Comments
Congenital Heart Disease			
Heart Murmur			
Current or recent Cold/Sore Throat			
Asthma			
RSV			
Bronchiolitis			
Croup			
Broken Bones			
Scoliosis			
Diabetes			
Headaches			
Seizures			
Depression			
ADHD			
Down's Syndrome			
Mental Retardation			
Autism			
Developmental Delay			
Reflux / Persistent Vomiting			
Bowel Problems			
Anemia / Bleeding Disorders			
Vision Problems			
Ear Problems			
Overweight			
Rashes			
Other:			

Female Children:

Have periods started? \_\_\_\_\_

What age? \_\_\_\_\_

1st day of last menstrual period \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_