Paediatric Pre-operative Health Questionnaire

Surname: .... NHI: ....
First Names: ....
Date of Birth: ..../......./........ Sex: ....
PLACE PATIENT ID HERE

ANAESTHESIA

To be completed by patient's parent, guardian, or caregiver.

Patient's details	
Today's date:	Child's height: cm
Child's BMI:	Child's weight: kg
Proposed surgery / procedure:	

Your details	
Your name:	
Your relationship to the child:	
Are you the child's legal guardian?	☐ Yes ☐ No
Home phone:	Work phone:
Cell:	Email:
Do you speak and understand English? If not, what is your first language?	☐ Yes ☐ No
Are you happy for us to leave a message?	☐ Yes ☐ No
When is the best time for you to receive telephone calls from staff?	

CCDHB use only		
Health questionnaire assessed by (name and position).		
Name:	Designation:	Date: / /
Pre-anaesthesia requirements:		
☐ Phone call PA nurse	☐ Phone call CNS	☐ Paediatric Specialist Clinic

Do any of the following medical conditions affect your child? *Please tick 'yes' or 'no' and comment as required.*		
Premature birth. If so, how many weeks premature?	☐ Yes	☐ No
Near miss cot death.	☐ Yes	☐ No
Breathing problems *e.g. asthma, croup, or frequent chest infection.* **Please bring peak flow recordings with you if available.**	☐ Yes	☐ No
Has your child needed steroids for breathing problems. **When was your child's last course:**	☐ Yes	☐ No
Sleep apnoea *e.g. heavy snoring and breath holding when sleeping.*	☐ Yes	☐ No
Heart conditions *e.g. rheumatic fever or heart murmur, congenital heart disease.*	☐ Yes	☐ No
Heart or lung surgery.	☐ Yes	☐ No
Fainting spells.	☐ Yes	☐ No
Brain, or spinal cord problems *e.g. cerebral palsy, spina bifida, developmental delay, autism.*	☐ Yes	☐ No
Seizures, fits, or epilepsy. How often does your child have seizures? When was your child's last seizure?	☐ Yes	☐ No
Muscle disease *e.g. muscular dystrophy.*	☐ Yes	☐ No
Problem keeping up physically with children of similar age.	☐ Yes	☐ No
Reflux.	☐ Yes	☐ No
Kidney (renal) problems.	☐ Yes	☐ No
Liver problems.	☐ Yes	☐ No
Diabetes. Please bring blood sugar recordings with you if available.	☐ Yes	☐ No
Abnormal bleeding or bruising.	☐ Yes	☐ No
Medical syndrome *e.g. Downs Syndrome, Pierre Robin, Goldenhar, Treacher Colins.*	☐ Yes	☐ No
Are there any conditions that run in your family *e.g. malignant hyperthermia, thalassaemia, muscular dystrophy.*	☐ Yes	☐ No

Exposure to measles, chickenpox or any other infectious diseases in the last three weeks. If so, what? ☐ Yes ☐ No

Other medical information you think is important

Medications

Please list **all medications** your child currently takes including the dose and how often they take the medication in a day. *This includes tablets, injections, contraceptive pills, inhalers, puffers, eye drops, patches, etc*. Please also include over-the-counter and any complementary, herbal, homeopathic or other alternative therapies.

Name of medicine / therapy	Dose	Frequency

Allergies

Does your child have any allergies or reactions to medicines, sticking plasters, food, paint, latex/rubber products, x-ray dyes, or anything else that you know of? ☐ Yes ☐ No

If YES, please give details (what are they allergic to, what happens, etc.)

Has your child ever been admitted to hospital before? ☐ Yes ☐ No

Operation / procedure / illness (most recent first)	Year	Hospital

Hospitals / clinics / doctors / surgeons / nurses who your child sees

Name	Reason	Date of last visit

Anaesthesia related issues

☐ Has your child had any problems with previous anaesthesia?

☐ Have any blood relatives had problems with anaesthesia? If yes, please describe:

☐ Has your child attended a pre-anaesthesia assessment before? When was the last time?

Is there anything in particular you would like to discuss?

Discharge planning

☐ Does your child require any physical support or aids? Please explain:

☐ Are you currently using any community support services? Please list:

Declaration

The above health information is a true and accurate account of my child's health status.

Signature of parent, guardian, or caregiver:	Date: / /

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