*Name:*

*Date of Birth:*

*Hospital No: (if known)*

**Paediatric Pre-Operative Health Questionnaire**

**For children and young adults aged <16 yrs**

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

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| **Patient's details** | | | | | | |
| Today's date: | | Child's height: | | | | cm |
| Proposed date of surgery (if known): | | Child's weight: kg | | | | |
| Proposed surgery / procedure (if known): | | | | | | |
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| **Your details** | | | | | | |
| Your name: | | | | |  | |
| Your relationship to the child: | | | | |  | |
| Are you the child's legal guardian? ⃝ Yes ⃝ No | | | | | | |
| Home phone: | | Mobile phone: | | |  | |
| 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? | | | | |  | |
|  | | | | | | |
| **DGHNHSFT use only** | | | | | | |
| Health questionnaire assessed by (name and position). | | | | | | |
| Signature: | Stamp: | | Designation: | Date: | | |
| Pre-anaesthesia requirements:  Fit for Theatre ⃝ Phone call ⃝ Paediatric Specialist Clinic ⃝ | | | | | | |

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| **Do any of the following medical conditions affect your child?**  **Please tick 'yes' or 'no' and add comment/detail if possible.** |  | |
| **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*  **If you know their recent Peak Flow readings, please add them here.** | | **⃝ 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** |
| **Developmental, brain, or spinal cord problems** **or other cause of disability** *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.**  **If you know their usual blood sugar range, please add it here.** | | **⃝ Yes ⃝ No** |
| **Abnormal bleeding or bruising.** | | **⃝ Yes ⃝ No** |
| **Medical syndrome** *e.g. Downs Syndrome, Pierre Robin, Goldenhar, Treacher Collins.* | | **⃝ 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** |

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| **Recent Cough or Cold** | | | |
| **Has your child had a cough, cold or fever in the 6 weeks before surgery?**  Note: a clear runny nose or dry cough in a child who is otherwise well is not usually a concern | | | **⃝ Yes ⃝ No** |
|  | | |  |
| **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** | |
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| **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** | |
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| **Other medical information you think is important** | | | |
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| **Hospitals / clinics / doctors / surgeons / nurses who your child sees** | | |  |
| **Name** | **Reason** | **Date of last visit** | |
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| **Anaesthesia related issues**  ID sticker | | | |
| Has your child had any problems with previous anaesthesia? | | | **⃝ Yes ⃝ No** |
| Have any blood relatives had problems with anaesthesia? If yes, please describe: | | | **⃝** **Yes** **⃝ No** |
| Has your child attended a pre-anaesthesia assessment before? When was the last time? | | | ⃝ Yes ⃝ No |
|  | | | |
| **Is there anything in particular about the anaesthetic 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: | Print name: | Date: | |

If you have any questions, or if there is anything you do not understand, please contact:

**Pre-operative Assessment Unit** on 01384 456111 ext. 1849

(7am to 7.30pm, Monday to Friday)

Please return this questionnaire by post to:

*FAO: Anaesthetic Preassessment Consultant, Surgical Preassessment, Level 1, Russells Hall Hospital, Dudley, DY1 2HQ.*