Paediatric Pre-Operative Health Questionnaire

For children and young adults aged <16 yrs

Name:

Date of Birth:

Hospital No: (if known)

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

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):	

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.

Condition	Answer
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? ◯ Yes ◯ No
Note: a clear runny nose or dry cough in a child who is otherwise well is not usually a concern

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

Other medical information you think is important

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

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Name	Reason	Date of last visit

Anaesthesia related issues

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. 2436

(08:00-18:30, Monday to Friday)

Please return this questionnaire by post to:

FAO: Anaesthetic Preassessment Consultant, Surgical Preassessment, Ground floor,North Wing, Russells Hall Hospital, Dudley, DY1 2HQ.