FAMILY QUESTIONNAIRE

WOLFSON CHILDREN'S HOSPITAL at BAPTIST MEDICAL CENTER, Jacksonville, FL

PRE-ANESTHESIA ASSESSMENT: The following questions have been designed for use by the Departments of Anesthesia and Pediatrics for the purpose of providing your child with the best possible care. Please answer each question carefully, then return the form to the nurse.

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

CONDITION:	NO	YES	EXPLANATION:
ASTHMA/WHEEZING			
IF YES, ORAL STEROIDS IN THE LAST YEAR			
BRONCHITIS, PAST 4 WEEKS			
COLD or COUGH, PAST 2 WEEKS			
FEVER, RECENT			
HEART DEFECT or MURMUR			
HIGH/LOW BLOOD SUGAR			
SEIZURES			
VOMITING/DIARRHEA, RECENT			
BIRTH DEFECTS			
BREATHING PROBLEMS			
EXCESSIVE BLEEDING/ANEMIA			
HEPATITIS/JAUNDICE			
MUSCLE WEAKNESS			
NUMBNESS or PARALYSIS			
PNEUMONIA			
PREMATURITY			
SORES/RASH (skin or mouth)			
SWALLOWING PROBLEMS			
THYROID PROBLEMS			
URINARY PROBLEMS			
BEHAVIORAL PROBLEMS			
CAPPED/LOOSE TEETH (which)			
EARACHES/INFECTIONS			
NOSEBLEEDS			
SNORING			
DOES CHILD HAVE BREATHING PAUSES			
TOBACCO SMOKE EXPOSURE			
OTHER (specify)			

ALLERGIES: NONE ☐	TYPE OF REACTION:
MEDICATION ALLERGIES:	
FOOD ALLERGIES:	
LATEX/RUBBER ALLERGIES:	

LIST ANY MEDICATIONS YOUR CHILD TAKES: NONE ☐

HAS YOUR CHILD BEEN TESTED FOR SICKLE CELL? RESULTS:

HAS YOUR CHILD HAD PREVIOUS HOSPITALIZATIONS/SURGERIES: NONE ☐

PLEASE LIST: ____________________

IF YES WHERE? ____________________

IS THERE ANY FAMILY HISTORY OF PROBLEMS WITH ANESTHESIA: NONE ☐

EXPLAIN: ____________________

WHO IS YOUR CHILD'S PRIMARY PHYSICIAN?

IS YOUR CHILD FOLLOWED BY ANY OTHER PHYSICIANS?

INFORMATION FROM: ____________________

PHONE NUMBER: ____________________

PARENT/GUARDIAN COMPLETING FORM SIGNATURE: ____________________ DATE: __________ TIME: ______

SURGICAL OFFICE STAFF

(SURGERY DATE)

(PATIENT'S NAME) (PATIENT'S DOB)

SURGEON:

PROCEDURE:

HEIGHT: ______ cm WEIGHT: ______ kg IN CLINIC

ANESTHESIA PROVIDER

ASA CLASSIFICATION:

TYPE ANESTHESIA PLANNED:

PHYSICAL EXAM: ☐ V/S CHECKED & OK AIRWAY:

LUNGS:

C-V:

ANESTHESIOLOGIST SIGNATURE: DATE: TIME:

ENTRY DATE AND TIME AND SIGNATURE DATE AND TIME ARE IDENTICAL

Wolfson Children's Hospital Jacksonville, FL

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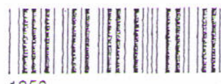
PRE-ANESTHESIA ASSESSMENT



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PATIENT LABEL