



**Johns Hopkins Medical Institutions**  
**Department of Anesthesiology and Critical Care**  
**Medicine, Division of Pediatric Anesthesia**  
**Pre-Anesthesia Pediatric Patient Questionnaire**



Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_  
 Your Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Your Home Phone \_\_\_\_\_ Work/Cell Phone \_\_\_\_\_  
 Pediatrician or Clinic \_\_\_\_\_ Pediatrician Phone \_\_\_\_\_

**Child's Medical History**

1. Medication or Food Allergies:  None Known  Yes If Yes, to what? \_\_\_\_\_  
 \_\_\_\_\_

2. Medications: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

3. Previous Surgery or Anesthesia  None  Yes (If yes, please write them below)

Procedure	At what age?	What hospital?

4. Previous Hospitalizations  None  Yes (If yes, please write them below)

Reason for Hospitalization	At what age?	What hospital?

5. Any problems with anesthesia in the past?  None  Yes If yes, what happened? \_\_\_\_\_  
 \_\_\_\_\_

6. Is there a family history of anesthetic problems?  None  Yes If yes, what happened? \_\_\_\_\_  
 \_\_\_\_\_

7. Was your child premature?  No  Yes If yes, how early? \_\_\_\_\_  
 What was the birth weight? \_\_\_\_\_ Birth place: \_\_\_\_\_  
 Was your child in a neonatal intensive care unit?  No  Yes If yes, how long? \_\_\_\_\_  
 Was your child on a ventilator  No  Yes If yes, how long? \_\_\_\_\_

8. Has your child been on an apnea monitor?  No  Yes If yes, is he/she on one now?  No  Yes If no, when was it discontinued? \_\_\_\_\_

9. Has your child ever had chicken pox?  No  Yes Chicken pox vaccine?  No  Yes Has your child been exposed to chicken pox in the past 3 weeks?  No  Yes

10. Medical Problems (check if yes and explain)

- Cough or runny nose in past month \_\_\_\_\_
- Fever in the past month \_\_\_\_\_
- Sore throat or hoarseness in past month \_\_\_\_\_
- Difficulty breathing \_\_\_\_\_
- Croup (barking cough) or stridor \_\_\_\_\_
- Asthma or wheezing \_\_\_\_\_
- Pneumonia \_\_\_\_\_
- Acid Reflux or Heartburn \_\_\_\_\_
- Aspiration or choking episodes \_\_\_\_\_
- Swallowing or Eating Problems \_\_\_\_\_
- Heart Murmurs or Irregular Heart Beat \_\_\_\_\_
- Other Heart Problems \_\_\_\_\_
- Nausea, vomiting or diarrhea in past month \_\_\_\_\_
- Recent weight loss \_\_\_\_\_
- Kidney Problems \_\_\_\_\_
- Liver Problems \_\_\_\_\_
- Hepatitis \_\_\_\_\_
- Previous Blood Transfusions; when was the last transfusion? \_\_\_\_\_
- Bleeding Problems \_\_\_\_\_
- Anemia or low blood count \_\_\_\_\_
- Sickle Cell Disease \_\_\_\_\_
- Seizures \_\_\_\_\_
- Thyroid Problems \_\_\_\_\_
- Muscle or Bone Problems \_\_\_\_\_
- Cerebral Palsy \_\_\_\_\_
- Developmental Delay \_\_\_\_\_
- Snoring or sleep apnea \_\_\_\_\_
- HIV / AIDS \_\_\_\_\_

11. Is your child able to keep up playing with children of similar age?  Yes  No If no, please explain \_\_\_\_\_

12. Are there smoker's in the house?  No  Yes

Is there anything else we should know about your child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

Please fax or mail completed questionnaire -

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