

Appendix A. Preoperative Screening Questionnaire
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 smokers 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 -

FAX: 410-502-5312

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