Hamilton Health Sciences

Preoperative Patient Questionnaire - Pediatric

Patient's Last Name First Name

Address Street

City Province Postal Code

Health Card Number

Patient's Birthdate (yyyy/mm/dd) Age Sex ☐ M ☐ F

Date (yyyy/mm/dd)_____

Surgery_____

Name of person completing this form (if not the patient)_____

Relationship to patient_____

Name your child likes to be called: _____

Previous operations and / or hospital stays	Date (yyyy/mm/dd)	Previous operations and / or hospital stays	Date (yyyy/mm/dd)
1.		6.	
2.		7.	
3.		8.	
4.		9.	
5.		10.	

History	What was your birth weight _____ ☐ pounds ☐ kilograms					
	Were you born before 37 weeks gestation?				☐ No	☐ Yes
	Have you ever had an anaesthetic including sedation for dental procedures?				☐ No	☐ Yes
	Have you had any problems with anesthesia such as unusual temperature changes or trouble breathing?				☐ No	☐ Yes
	Do you have a blood relative who has had any problems with anesthesia such as unusual temperature changes or trouble breathing?				☐ No	☐ Yes
Mouth	Do you have any loose teeth, capped teeth, braces or a retainer?				☐ No	☐ Yes
	Do you have difficulty opening your mouth fully?				☐ No	☐ Yes
Heart	Do you have difficulty walking up two flights of stairs without stopping?				☐ No	☐ Yes
	Do you have difficulty keeping up with and playing with children your age?				☐ No	☐ Yes
	Have you ever had rheumatic fever?				☐ No	☐ Yes
	Have you ever had a heart murmur?				☐ No	☐ Yes
	Have you ever had an irregular heart beat?				☐ No	☐ Yes
	Have you ever had a stroke or a mini stroke?				☐ No	☐ Yes
	Have you ever had a blood clot?				☐ No	☐ Yes
	Have you ever taken a medication to thin your blood?				☐ No	☐ Yes
Breathing	Do you smoke?	☐ No	☐ Yes	Do you use oxygen at home?	☐ No	☐ Yes
	Do you live in a smoking environment?	☐ No	☐ Yes	Do you have cystic fibrosis?	☐ No	☐ Yes
				Have you ever had croup?	☐ No	☐ Yes

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Breathing - Continued	Do you currently have a cough with mucous or sputum?	☐ No	☐ Yes
	Have you ever been told that you have asthma?	☐ No	☐ Yes
	Have you ever been told that you have tuberculosis, emphysema or chronic bronchitis?	☐ No	☐ Yes
	Have you ever taken a steroid orally or injected? (e.g. prednisone or cortisone)	☐ No	☐ Yes
Liver / Stomach	Do you have a liver disease?	☐ No	☐ Yes
	Have you ever been told you had hepatitis?	☐ No	☐ Yes
	Have you ever been jaundiced, even as an infant (yellow colour of your skin)?	☐ No	☐ Yes
	Do you have a bowel disease?	☐ No	☐ Yes
	Have you ever been told you have an ulcer?	☐ No	☐ Yes
	Have you ever been told you have a metabolic disorder?	☐ No	☐ Yes
Renal / Endocrine	Do you have diabetes?	☐ No	☐ Yes
	Do you have thyroid problems?	☐ No	☐ Yes
	Do you have kidney disease?	☐ No	☐ Yes
	Are you on dialysis?	☐ No	☐ Yes
Brain / Nerve	Have you ever been diagnosed with epilepsy, seizures or convulsions?	☐ No	☐ Yes
	Do you have a disease that affects your muscles or nerves?	☐ No	☐ Yes
	Have you ever been diagnosed with a brain tumour?	☐ No	☐ Yes
	Do you have cerebral palsy?	☐ No	☐ Yes
	Do you have anxiety?	☐ No	☐ Yes
	Have you ever been diagnosed with ADHD (Attention Deficit Hyperactivity Disorder)?	☐ No	☐ Yes
Blood	Have you ever been told that you have a bleeding problem?	☐ No	☐ Yes
	Have you ever been told you have sickle cell disease?	☐ No	☐ Yes
	Have you ever been anaemic or been told you have low iron?	☐ No	☐ Yes
	Have you ever had a blood transfusion?	☐ No	☐ Yes
	Have you ever had a reaction to a blood transfusion?	☐ No	☐ Yes
	Would you have any objection to receiving blood products in an emergency situation?	☐ No	☐ Yes

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Other	Do you use recreational or street drugs?	☐ No	☐ Yes
	Are all of your vaccinations up to date?	☐ No	☐ Yes
	Have you ever had chicken pox?	☐ No	☐ Yes
	Have you been in contact with chicken pox in the last 4 weeks? ☐ No ☐ Yes → When? _____		
	Have you been in contact with any communicable diseases in the last 4 weeks? ☐ No ☐ Yes → What disease and when? _____		
	Have you ever been told you have a learning disorder?	☐ No	☐ Yes
	Have you ever been told you have a syndrome or chromosomal disorder?	☐ No	☐ Yes

Female Patients Only Could you be pregnant at this time? ☐ No ☐ Yes ☐ N/A

Date of last Menstrual period (yyyy/mm/dd) _____

Please write down any concerns that may affect your care either in hospital or at home that we should be aware of before your surgery.

Pediatric Properative Patient Questionnaire Reviewed By:

Printed Name	Signature & Designation	(yyyy / mm / dd)
Printed Name	Signature & Designation	(yyyy / mm / dd)
Printed Name	Signature & Designation	(yyyy / mm / dd)

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Pre Surgery Medication List

Patient's Birthdate (yyyy/mm/dd) Age Sex ☐ M ☐ F

Date: (yyyy/mm/dd)_____

Please list all medications you take including: • Prescription - including inhalers (puffers), insulin and patches • Vitamins / Supplements / Diet Pills • Herbal • Over the counter products • Eye / Ear drops • Nasal Mists	**Dose** (Strength)	**How Often Taken**	**When** Morning (am) Afternoon (aft) Evening (eve) Bedtime (pm)

Rx **Please bring all your prescription medication containers and non-prescription medication containers with you to the Pre-Op Clinic**



• including inhalers (puffers) and insulin •