784-007
2/04

NOTE: If the patient is unable to complete this form, the family and/or friends are asked to help complete the information.

Your physician has arranged for a qualified physician anesthesiologist to give your anesthetic. PLEASE answer completely the following medical history questions. Your answers affect our choice of anesthetic, and they may prevent the occurrence of undesirable responses to anesthesia. Please complete or encircle the appropriate answers, and sign your name. On the day of surgery, you will be asked to sign a consent for anesthesia.

Who is your child's primary physician? ____________________ City ____________ Child's weight ________ Child's height ________

Is your child followed by any other physicians? ____________________

Information Source: ❑ parent, ❑ guardian, ❑ other ____________________

CONDITION:	NO	YES	EXPLANATION:
1. ASTHMA/WHEEZING			
2. BRONCHITIS, PAST 4 WEEKS			
3. COLD or COUGH, PAST 2 WEEKS			
4. FEVER, RECENT			
5. HEART DEFECT or MURMUR			
6. HIGH/LOW BLOOD SUGAR			
7. SEIZURES			
8. VOMITING/DIARRHEA, RECENT			
9. BIRTH DEFECTS			
10. BREATHING PROBLEMS			
11. EXCESSIVE BLEEDING/ANEMIA			
12. HEPATITIS/JAUNDICE			
13. MUSCLE WEAKNESS			
14. NUMBNESS or PARALYSIS			
15. PNEUMONIA			
16. PREMATURITY			
17. SORES/RASH (skin or mouth)			
18. SWALLOWING PROBLEMS			
19. THYROID PROBLEMS			
20. URINARY PROBLEMS			
21. BEHAVIORAL PROBLEMS			
22. BRACES			
23. CAPPED/LOOSE TEETH (which)			
24. EARACHES/INFECTIONS			
25. NOSEBLEEDS			
26. SNORING			
27. VISION/HEARING PROBLEMS			
28. SICKLE CELL DISEASE (you or family)			
29. OTHER: (specify)			

ALLERGIES: NONE ❑	TYPE OF REACTION:
MEDICATION ALLERGIES:	
FOOD ALLERGIES:	
LATEX/RUBBER PRODUCT ALLERGIES:	

Have you taken cortisone or steroid within the past six months? ❑ Yes ❑ No

List any medications your child takes: None ❑ ____________________

Has your child had previous hospitalizations/surgeries: None ❑

Please List: ____________________

PATIENT IDENTIFICATION

NORTH FLORIDA SURGICAL PAVILION

Pediatrics Anesthesia Questionnaire and Evaluation Form

Is there any family history of problems with anesthesia: None ❑
Explain: ____

Female Patients Only: Are you pregnant? ❑ Yes ❑ No Date of last period: / /

Many of the medications used in general or regional anesthesia have not been proven to be safe or unsafe for the fetus in known or undetected pregnant patients.

For infants less than 6 months old only: Was this infant born prematurely? ❑ Yes ❑ No If yes, how many weeks prematurely? ______ weeks

Is there any family history of Sudden Infant Death Syndrome (SIDS)? ❑ Yes ❑ No

Please remove contact lenses and partial dentures before you come to the operating room suite. Crowns, carious or loose teeth, and dental appliances may be damaged if you bite down on the plastic airways and tubes that may be placed in your mouth during anesthesia. We cannot be held responsible for this type of damage. Please ask your anesthesiologist regarding full dentures.

Signature of patient or patient's guardian	Signature of witness if patient is unable to sign	Date:	Time:

Please Note: Your anesthesiologist's professional services are NOT included in your hospital bill. Anesthesia charges noted by the Surgical Pavilion are for **supplies and medication only**. The anesthesiologist's fees are based on the surgical procedure (the more complicated the surgery, the more difficult the anesthesia) and the time the anesthesiologist is in attendance. Your anesthesiologist will bill you separately for professional services.

Patient should not write below this line.

For Physician Use Only

ASA CLASSIFICATION: 1 2 3 4 5 E

Risks, alternatives and complications discussed with patient. I have explained with accepted medical judgement the nature and purposes of the anesthesia planned and the reasonable anesthetic alternatives as well as the possible complications of the planned anesthetic.

Plan:

Exam:

Date / Time Physician's Signature M.D.

Post operative Notes:

☐ MEETS DISCHARGE CRITERIA

Date / Time Physician's Signature M.D.