

Pediatric Preoperative Anesthesia Questionnaire

Full name: _____

Date of birth (age): _____

Home address: _____

Telephone number: _____

Weight and height: _____

Please read the questionnaire carefully and answer all the questions.

Dear Parents,

Surgical procedures and painful examinations are performed under anesthesia. The anesthesiologist is responsible for the patient's care throughout the entire perioperative period. Completing this questionnaire accurately and thoroughly will help us properly assess your child's health before anesthesia. Each question relates to certain risk factors associated with anesthesia.

****Please underline the appropriate answer.***

1. Has your child received medical treatment during the past 12 months?

YES / NO

If yes, what was the reason/diagnosis?

2. Has your child recently taken or is your child currently taking any medications? YES / NO

If yes, which ones?

3. Is your child currently taking any dietary supplements? YES / NO

If yes, which ones?

4. Has your child ever undergone surgery? YES / NO

If yes, when and for what reason?

5. Did your child experience any complications during anesthesia? YES / NO

If yes, what kind?

6. Have any close relatives of your child experienced unexplained complications related to anesthesia? YES / NO

If yes, what kind?

7. Does your child have any muscle disorders or muscle weakness (myasthenia)? YES / NO

8. Have any close relatives had or currently have such conditions? YES / NO

9. Does your child have porphyria? YES / NO

10. Is your child's physical capacity limited? Does your child develop bluish discoloration (cyanosis) during strenuous physical activity? Does your child experience severe shortness of breath during physical activity? YES / NO

11. Has your child been diagnosed with a heart defect? YES / NO

12. Does your child frequently suffer from bronchitis? YES / NO

13. Does your child have any other lung conditions? YES / NO

If yes, which ones?

14. Has your child had jaundice (other than physiological jaundice)? YES / NO

15. Does your child have an increased tendency to bleed? YES / NO

16. Does your child have a tendency to develop extensive bruising? YES / NO

17. Does your child currently have or have they ever had urinary tract infections? YES / NO

If yes, what kind?

18. Does your child have any diseases or disorders of the nervous system? YES / NO

If yes, which ones?

19. Has your child ever experienced seizures or convulsions during a fever? Has your child ever had non-febrile seizures? YES / NO

If yes, when?

20. Does your child suffer from any allergies? Has your child ever developed a rash after taking medications or exposure to other substances? YES / NO

If yes, which medications or substances?

21. Does your child have diabetes? YES / NO

22. Does your child have any loose teeth? YES / NO

23. Additional information (e.g. any other medical conditions not listed above):

Thank you.