*Name:*

*Date of Birth:*

*Hospital No: (if known)*

 **Paediatric Pre-Operative Health Questionnaire**

**For children and young adults aged <16 yrs**

To be completed by patient's parent, guardian, or caregiver.

|  |
| --- |
|  **Patient's details** |
| Today's date: | Child's height: | cm |
| Proposed date of surgery (if known): |  Child's weight: kg |
| Proposed surgery / procedure (if known): |
|  |
|  **Your details** |
| Your name: |  |
| Your relationship to the child: |  |
|  Are you the child's legal guardian? ⃝ Yes ⃝ No |
| Home phone: | Mobile phone: |  |
|  Do you speak and understand English? If not, what is your first language? ⃝ Yes ⃝ No |
|  Are you happy for us to leave a message? ⃝ Yes ⃝ No |
| When is the best time for you to receive telephone calls from staff? |  |
|  |
| **DGHNHSFT use only** |
| Health questionnaire assessed by (name and position). |
| Signature: | Stamp: | Designation: | Date: |
| Pre-anaesthesia requirements: Fit for Theatre ⃝ Phone call ⃝ Paediatric Specialist Clinic ⃝ |

ID sticker

|  |  |
| --- | --- |
| **Do any of the following medical conditions affect your child?** **Please tick 'yes' or 'no' and add comment/detail if possible.** |  |
| **Premature birth**. If so, how many weeks premature?  | **⃝ Yes** **⃝ No**  |
| **Near miss cot death.**  | **⃝ Yes ⃝ No** |
| **Breathing problems** *e.g. asthma, croup, or frequent chest infection* **If you know their recent Peak Flow readings, please add them here.**  | **⃝ Yes ⃝ No**  |
| **Has your child needed steroids for breathing problems?****When was your child's last course**: | **⃝ Yes ⃝ No**  |
| **Sleep apnoea** *e.g. heavy snoring and breath holding when sleeping.*  | **⃝ Yes ⃝ No**  |
| **Heart conditions** *e.g. rheumatic fever or heart murmur, congenital heart disease.* | **⃝ Yes ⃝ No**  |
| **Heart or lung surgery.**  | **⃝ Yes ⃝ No**  |
| **Fainting spells.**  | **⃝ Yes ⃝ No**  |
| **Developmental, brain, or spinal cord problems** **or other cause of disability** *e.g. cerebral palsy, spina bifida, developmental delay, autism,*  | **⃝ Yes ⃝ No**  |
| **Seizures, fits, or epilepsy.**How often does your child have seizures? When was your child's last seizure? | **⃝ Yes ⃝ No**  |
| **Muscle disease** *e.g. muscular dystrophy.*  | **⃝ Yes ⃝ No**  |
| **Problem keeping up physically with children of similar age.**  | **⃝ Yes ⃝ No**  |
| **Reflux**.  | **⃝ Yes ⃝ No**  |
| **Kidney (renal) problems.**  | **⃝ Yes ⃝ No**  |
| **Liver problems.**  | **⃝ Yes ⃝ No**  |
| **Diabetes.****If you know their usual blood sugar range, please add it here.**  | **⃝ Yes ⃝ No**  |
| **Abnormal bleeding or bruising.**  | **⃝ Yes ⃝ No**  |
| **Medical syndrome** *e.g. Downs Syndrome, Pierre Robin, Goldenhar, Treacher Collins.*  | **⃝ Yes ⃝ No**  |
| **Are there any conditions that run in your family** *e.g. malignant hyperthermia, thalassaemia, muscular dystrophy.* | **⃝ Yes ⃝ No**  |
| **Exposure to measles, chickenpox or any other infectious diseases in the last three weeks. If so, what?** | **⃝ Yes ⃝ No**  |

ID sticker

|  |
| --- |
| **Recent Cough or Cold** |
| **Has your child had a cough, cold or fever in the 6 weeks before surgery?** Note: a clear runny nose or dry cough in a child who is otherwise well is not usually a concern |  **⃝ Yes ⃝ No**  |
|  |  |
| **Medications** |
| Please list **all medications** your child currently takes including the dose and how often they take the medication in a day. This includes tablets, injections, contraceptive pills, inhalers, puffers, eye drops, patches, etc. Please also include over-the-counter and any complementary, herbal, homeopathic or other alternative therapies. |
| **Name of medicine / therapy** | **Dose** | **Frequency** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |
| **Allergies** |
| Does your child have any allergies or reactions to medicines, sticking plasters, food, paint, latex/rubber products, x-ray dyes, or anything else that you know of? | **⃝ Yes ⃝ No**  |
| If YES, please give details (what are they allergic to, what happens, etc.) |
|  |
| **Has your child ever been admitted to hospital before?** | **⃝ Yes ⃝ No**  |
| **Operation / procedure / illness** (most recent first) | **Year** | **Hospital** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Other medical information you think is important** |
|  |

|  |
| --- |
|  |
| **Hospitals / clinics / doctors / surgeons / nurses who your child sees** |  |
| **Name** | **Reason** | **Date of last visit** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |

|  |
| --- |
| **Anaesthesia related issues**ID sticker |
| Has your child had any problems with previous anaesthesia? | **⃝ Yes ⃝ No**  |
| Have any blood relatives had problems with anaesthesia? If yes, please describe: | **⃝** **Yes** **⃝ No**  |
| Has your child attended a pre-anaesthesia assessment before? When was the last time? | ⃝ Yes ⃝ No |
|  |
| **Is there anything in particular about the anaesthetic you would like to discuss?** |
|  |
| **Discharge planning**⃝ Does your child require any physical support or aids? Please explain: |
| ⃝ Are you currently using any community support services? Please list: |
|  |
| **Declaration** |
| The above health information is a true and accurate account of my child's health status. |
| Signature of parent, guardian, or caregiver: | Print name: | Date: |

If you have any questions, or if there is anything you do not understand, please contact:

**Pre-operative Assessment Unit** on 01384 456111 ext. 1849

 (7am to 7.30pm, Monday to Friday)

Please return this questionnaire by post to:

*FAO: Anaesthetic Preassessment Consultant, Surgical Preassessment, Level 1, Russells Hall Hospital, Dudley, DY1 2HQ.*