

PREOPERATIVE QUESTIONNAIRE

PATIENT'S NAME: _____

Date of Birth : _____

OHIP/Health Card # : _____

- 1. How old is your child? _____
- 2. How much does your child weigh? _____ (Kg) or _____ (lbs.)
- 3. What surgery is your child going to have? DENTAL
- 4. Has your child ever been admitted to hospital? **YES NO**
- 5. Was your child born prematurely? **YES NO**
- 6. Has your child ever had general anesthesia or surgery? **YES NO DON'T KNOW**
If yes, where/ when/ why: _____
- 7. Did your child have any problems with the anesthetic? **YES NO DON'T KNOW**
If yes, please explain: _____
- 8. Is there a history of problems with anesthesia in the family? **YES NO DON'T KNOW**
If yes, please explain: _____
- 9. Is your child presently receiving any medication? **YES NO DON'T KNOW**

If yes,

Name	Date Started	Reason for Taking it

- 10. Does your child have any allergies including drug allergies? **YES NO DON'T KNOW**
If yes, (a)What are they? _____
(b) Has the allergy required admission to the hospital? **YES NO DON'T KNOW**
- 11. Has your child had a cold or a cough within the last 2 weeks? **YES NO DON'T KNOW**
If yes, (a)Any associated fevers? **YES NO DON'T KNOW**
(b) Is the cough producing mucus? **YES NO DON'T KNOW**
(c) Associated with runny nose? **YES NO DON'T KNOW**
(d) Associated decrease in their level of activity and appetite? **YES NO DON'T KNOW**

12. Does your child have cerebral palsy or any other neurological problems? **YES NO DON'T KNOW**

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- If yes, any** (a) Seizure disorder? **YES NO DON'T KNOW**
- (b) Reflux of stomach contents? **YES NO DON'T KNOW**
- (c) Recurrent pneumonia's? **YES NO DON'T KNOW**
- (d) Aggressive tendencies? **YES NO DON'T KNOW**
- (e) Difficulty communicating? **YES NO DON'T KNOW**

- 13. Does your child have asthma?..... **YES NO DON'T KNOW**
- If yes,** (a) Is it presently requiring treatment? **YES NO DON'T KNOW**
- (b) Required admission to the Intensive Care Unit? **YES NO DON'T KNOW**
- (c) Have there been more than 2 bouts in the last 6 months?..... **YES NO DON'T KNOW**
- (d) Required oral steroid pills in the last 6 months?..... **YES NO DON'T KNOW**

- 14. Does your child have heart problems?..... **YES NO DON'T KNOW**
- If yes,** (a) What is it? _____
- (b) Has it required surgery?**YES NO DON'T KNOW**
- (c) Does your child tire easily?.....**YES NO DON'T KNOW**

- 15. Does your child have a muscle disease? **YES NO DON'T KNOW**
- If yes,** what is the diagnosis: _____

- 16. Does your child have a low red blood cell count (anemia)? **YES NO DON'T KNOW**
- If yes,** has it required treatment?**YES NO DON'T KNOW**

- 17. Does your child: (a) Have a history of easy bruising? **YES NO DON'T KNOW**
- (b) Had excessive amount of bleeding following minor surgery? ...**YES NO DON'T KNOW**
- (c) Have a family history of bleeding problems?**YES NO DON'T KNOW**

- 18. Does your child have any difficulty with head or neck movement or mouth opening?
YES NO DON'T KNOW
- 19. Does your child have any other medical problems that have not been addressed
in the previous questions? **YES NO DON'T KNOW**
- If yes,** please specify: _____

- 20. Does your child smoke? **YES NO DON'T KNOW**
- 21. Do you or your child have any specific questions or concerns regarding anesthesia that you prefer to address
with an anesthetist prior to the day of surgery?..... **YES NO DON'T KNOW**

Other comments: _____

Signature: _____ Date: _____

Telephone: (home) _____ (work) _____