Lucile Packard Children's Hospital Stanford

Pediatric Anesthesia Resource Center
Lucile Packard Children's Hospital
Questionnaire

This questionnaire is designed to assist the staff that will be taking care of your child for his/her procedure. It will help us to learn more about his/her health history and needs on the day of the procedure.

Please complete and have it with you on your appointment

Name of Parent: _____ Preferred Language:_____
Legal Guardian: _____

Contact Information:
Current Phone – Home: _____ Cell: _____
E-mail: _____
Indicate preferred manner for follow-up contact: Home phone / Cell / E-mail

Anticipated Phone Number during week prior to surgery if different than above:
_____

Medications:

Name:	Dose:	Time of day when medication given:
1.		
2.		
3.		
4.		
5.		
6.		

Allergies:

	Describe the allergic reaction:
1.	
2.	
3.	
4.	
5.	

Family History:
Allergic or unusual reactions to anesthesia in your child or a family member?
No ☐ Yes ☐ describe:
_____
_____

Surgical/Anesthetic history of child:

Procedure	Age at surgery	Problems?

Hospitalizations in the last 12 months:

Reason for Admission	Date	Hospital

Medical History:

	✓	Describe the illness
Recent Illness: Cold/Flu		
Frequent colds/cough		
Born Prematurely		
Behavioral Issues		
Developmental Delay		
Heart Condition		
Lung Condition		
Airway or Breathing Trouble		
Congenital/Genetic Syndrome		
Liver/Kidney/Stomach Issues		
Metabolic/Endocrine Problem		
Positioning Concerns		

Do you have any questions or concerns for the anesthesiologist to be aware of? (Please list/describe)

_____

_____

Previous poor experience with procedures yes/ no (please describe)

Perceived anxiety if no prior experience (please describe)

_____

_____

Thank you for your help in completing this questionnaire!