

## Pre-Anaesthesia Questionnaire (Child) cont'd

Name \_\_\_\_\_

Age \_\_\_\_\_

16. Does your child have or ever had any of the following?

	Yes	No	Not Sure		Yes	No	Not Sure
Heart murmur				Croup			
Congenital heart disease				Other lung diseases			
Chest pain or angina				Cancer / Chemotherapy			
Heart pacemaker/defibrillator				Fainting spells, dizziness			
Irregular heart beat/arrhythmia				Thyroid problems			
Damaged/abnormal heart valves				Glaucoma or vision problems			
Rheumatic fever				Muscular dystrophy			
Liver disease / Jaundice				Arthritis			
Hepatitis				Bone, joint or muscle problems			
Blood / Coagulation disorders				Stomach ulcers/Acid reflux			
Anemia (including sickle cell)				Sleep apnea			
Thalassemia				Pseudocholinesterase deficiency			
Kidney disease				Malignant hyperthermia			
Adrenal gland problems				Epilepsy/ Seizures/convulsions			
Diabetes				Cerebral palsy			
HIV, AIDS				Down's syndrome			
Asthma				Autism			
Cystic fibrosis / Tuberculosis				Mentally disabled			

- |  | Yes                      | No                       | Not Sure                 |
|--|--------------------------|--------------------------|--------------------------|
| 17. Does your child have any difficulty breathing through their nose?                  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Does your child have any nose bleeds? If so, how many per week? _____              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Does your child have problems running around and playing freely?                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Does your child get short of breath very easily?                                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Does your child ever turn a blue colour and/or faint when trying to run or play?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Does your child have any problems opening his/her mouth wide?                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Does your child have any problems moving his/her neck freely?                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Has your child ever had surgery and/or radiation treatment for a tumour or cancer? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Does your child smoke?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. If your child is of child bearing age, is she pregnant?                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Does your child have any loose teeth (especially front teeth)?                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Does your child have ANY disease, condition or problem not mentioned so far?       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. <b>How much does your child weigh?</b> _____                                       |                          |                          |                          |
| 30. Additional comments: _____   |                          |                          |                          |

<b>Signature:</b> _____	<b>Date:</b> _____
<b>Relationship:</b> <b>Parent</b> <b>Guardian</b> <b>Patient</b>	