BC CHILDREN'S HOSPITAL
An agency of the Provincial Health Services Authority

Department of Pediatric Anesthesia
Pre-Anesthesia Screening Questionnaire

Patient ID sticker

Planned procedure:______________________________ Planned date:____________________

Best contact number:____________________________ Email address:__________________

1. Has your child ever had an anesthetic before? ☐Yes ☐No ☐Unsure

If yes:

Operation/procedure	Date (mm/yy)	Hospital

Did your child have any problems with previous anesthetics, including problems at the start with the needle or mask? ☐Yes ☐No

2. Has anyone in the family ever had a problem with an anesthetic? ☐Yes ☐No ☐Unsure

If yes, please give details. We may call you to find out more information.

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3. Do you or your child have any specific concerns that you would like to discuss with an anaesthesiologist? ☐Yes ☐No

4. If your child has history of any of the following medical conditions, please mark all that apply.

	Heart murmur		Diabetes
	Heart disease		Thyroid disease
	Asthma		Bleeding disorder
	Cystic fibrosis		Developmental delay
	Obstructive sleep apnea		Cerebral palsy
	Epilepsy		Muscle disease
	Liver disease		Sickle cell disease
	Kidney disease		Behavioural-related spectrum disorder
	Cancer		Chronic pain
	Premature birth If Y: ....wks?		Any known syndrome If Y: Name......................................

Please turn over…

5. Has your child ever suffered from any of the following complaints? Please mark all that apply.

	Loud snoring		Recent infectious disease (e.g. chicken pox)
	Seizures		Frequent respiratory infections
	Fainting or blackouts		Frequent urinary tract infections
	Shortness of breath		Easy bruising or bleeding
	Heartburn/acid reflux		Jaundice after one month of age

6. Does your child take any **MEDICATIONS**? ☐Yes ☐No ☐Unsure

Please include details of **prescribed**, **over-the-counter** and **herbal/homeopathic** medications.

Drug Name	Dose/Amount	How Often

Please indicate specifically whether your child has received:

Steroid tablets or injections in the last six months ☐Yes ☐No ☐Unsure

Inhalers for asthma in the last month ☐Yes ☐No ☐Unsure

Aspirin in the last 14 days ☐Yes ☐No ☐Unsure

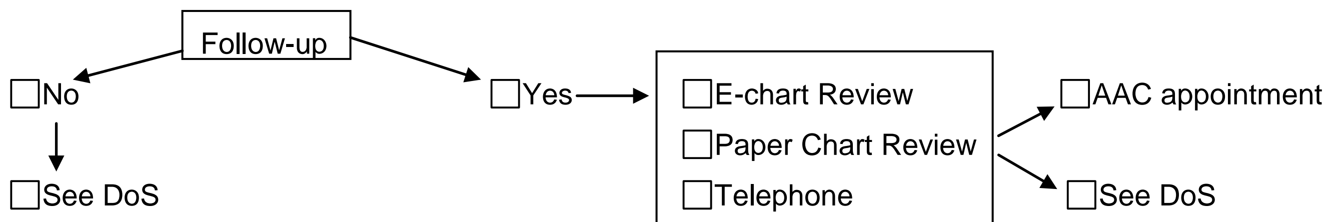
Immunizations in the last 2 weeks ☐Yes ☐No ☐Unsure

7. Does your child have any **ALLERGIES** that you know of? ☐Yes ☐No ☐Unsure

If yes:

Drug /Other	Details of reaction

For Department of Anesthesia Use Only



Reviewed by:___________________________

Referring Specialty:_____________________ Referring Physician:_____________________