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Dentist Anesthesiologist

Pre-Anesthesia Questionnaire

For Parent/Guardian or Patient

Name_____ Date_____ DOB (MM/DD/YY)_____

Weight: Height:

1. Has your child ever been in a hospital? Yes No
   If so, when and why?
2. Was you child born prematurely? Yes No Weight:
3. Has you child ever had general anesthesia or surgery? Yes No
   If so, when and why?
4. Were there any problems with the anesthetic? Yes No
   If yes, please explain:
5. Has anyone in your family or relatives had a problem during or after an anesthetic? Yes No
   If yes, please explain:
   Were tests done?
6. Has anyone in your family tested positive for Malignant Hyperthermia? Yes No
   If yes, who, when and what tests were performed?
7. Does your child have a drug allergy? Yes No
   What type of drug?
8. Does your child have other allergies? Yes No
   What the symptoms?
9. If your child has an allergy, were any of the following present?
   a. Skin rash Yes No
   b. Hives Yes No
   c. Wheezing or trouble breathing Yes No
   What was done to treat the problem?
10. Has you child had a head cold or cough within the past two weeks? Yes No
11. Is the cough producing mucous? Yes No
12. Does your child wear a dental plate/bridge/retainer/braces? Yes No
13. Does your child have any damaged or loose teeth? Yes No

14. Does your child take ANY medications currently? Yes No
What are these medications?
Name Dose
Name Dose
Name Dose

15. Does you child use or take ANY non-prescription remedies? Yes No
Name Dose
Name Dose

16. Has your child had a cortisone (steroid) type drug in the past year? Yes No
For what reason?
For how long?

17. Is there anyone in the family with a bleeding problem? Yes No

19. Has your child had an excessive amount of bleeding following Surgery such as tooth extraction? Yes No

20. Does your child bruise easily on areas other than the legs? Yes No

21. Does your child have any difficulty with head/neck/jaw movement? Yes No

22. Does your child have problems with muscles/joints/nervous system? Yes No

23. Has your child been exposed to any infectious diseases in the past month? Yes No

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

Anemia	Yes	No	Arthritis	Yes	No	Asthma	Yes	No
Seizures	Yes	No	Epilepsy	Yes	No	Convulsions	Yes	No
Croup	Yes	No	Cystic Fibrosis	Yes	No	Diabetes	Yes	No
Glaucoma	Yes	No	Hepatitis	Yes	No	Jaundice	Yes	No

High Blood Pressure	Yes	No	Heart disease	Yes	No
Kidney disease	Yes	No	Liver Disease	Yes	No
Malignant Hyperthermia	Yes	No	Lung Disease	Yes	No
GE Reflux	Yes	No	Tuberculosis	Yes	No
Developmental Delay	Yes	No			

25. Does your child smoke? Yes No

26. Does anyone in the home smoke? Yes No

27. If your child is of child bearing age, is she pregnant? Yes No
Does she take birth control pills/shots/medicine? Yes No

28. Are there any problems with your child's health not covered? Yes No

Additional Comments:

Parent/Guardian Name (Print): _____

Parent/Guardian Name (Sign): _____