34474-08

Children's Healthcare of Atlanta
Surgery Center at Meridian Mark Plaza, LLC

PRE-ANESTHETIC HISTORY SHEET (PLEASE PRINT)

Name________________________________

Date of Birth________________________

MRN#________________________________

Account/HAR#_________________________

PATIENT IDENTIFICATION

DATE OF SURGERY__________________ CHILD'S AGE______________ SEX M F HEIGHT___________ WEIGHT___________

SURGEON__________________________ OPERATION____

PLEASE CIRCLE THE CORRECT ANSWER OR FILL IN THE BLANK

1. Child's general health is: GOOD FAIR POOR Immunizations up to date? NO YES
   Had chicken pox? NO YES Recent exposure to chicken pox? NO YES Date:__________________
2. In the past 3 months, has he/she had a cold, cough, fever, sore throat? NO YES Any complaints now? NO YES
   If yes, explain____
   Has your child had a respiratory treatment in the last 3 months? NO YES When__________ REASON__________________
3. List previous dates of hospitalization(s) and reasons for the hospitalizations (include surgery) of your child.
   DATE __________ REASON______________________________ DATE__________ REASON__________________
   DATE __________ REASON______________________________ DATE__________ REASON__________________
   Previous visit to CHOA? NO YES REASON____
4. Has the child ever had a general anesthetic? NO YES Were there any **serious** problems? NO YES Explain__________________
   ______________________________ Has any family member had any **serious** problem with anesthesia? NO YES
   If yes, explain____
5. Allergies: (medication/food/latex)? NO YES To what? ______________________________
   ______________________________ Reaction: ______________________________
6. Does the child **currently** take any medicines/vitamins/herbs? NO YES List______________________________
   ______________________________ REASON______________________________
   Aspirin or ibuprofen last 7 days? NO YES Last time given:__________________ REASON__________________
   What medications does he/she take occasionally?______________________________
7. Has the child been tested for sickle cell? NO YES The child (Does / Does not) have sickle cell disease or trait (Circle correct choice)
8. Please check box if the child has had any of the following. **If yes to any of the following questions please provide name of Specialist.**

*(A) HEART OR BLOOD PROBLEMS. . . . . NO YES
- ☐ Heart Defect ☐ Bleeding Problems
- ☐ Heart Murmur ☐ Any Blood Transfusions
- ☐ Other______________________________

*(B) LUNG OR BREATHING PROBLEMS . . . . NO YES
- ☐ Asthma/Wheezing, When______ ☐ Croup, When______
- ☐ Bronchiolitis/Bronchitis, When______ ☐ Cystic Fibrosis
- ☐ Pneumonia, When______
- ☐ Other______________________________

*(C) NERVOUS SYSTEM PROBLEMS. . . . . NO YES
- ☐ Convulsions, Seizures, or Fits
- ☐ Cerebral Palsy ☐ Hydrocephalus
- ☐ Down's Syndrome ☐ Myelomeningocele
- ☐ Developmental Delay ☐ Autism
- ☐ Other______________________________

*(D) DIGESTIVE SYSTEM PROBLEMS . . . . NO YES
- ☐ Hepatitis ☐ Intestines or Bowels
- ☐ Liver ☐ Gastro-Esophageal Reflux
- ☐ Stomach ☐ Overweight

*(E) GLANDULAR PROBLEMS . . . . NO YES
- ☐ Diabetes ☐ Thyroid
- ☐ Other______________________________

(F) ☐ BIRTH PROBLEMS .... NO YES
- ☐ Prematurity______ Wks Early Birth Weight ____________
- ☐ Artificial Ventilation Needed? Apnea monitor_____ Last used____
- ☐ Is child twin? ☐ triplet?_____ Brain Bleed ____________
- ☐ Other ______________________________

*(G) KIDNEY OR BLADDER PROBLEMS
- ☐ Explain______________________________

(H) IF MENSTRUATION HAS STARTED .... NO YES
- Date of last menstrual period ____________
- Is there any possibility of pregnancy? .... NO YES

*(I) MUSCLE OR BONE/JOINT PROBLEMS....................... NO YES
- ☐ Muscle Disorder
- ☐ Bone Disease
- ☐ Joint Disease ☐ Rheumatoid Arthritis
- ☐ Other

(J) TEETH .... NO YES
- ☐ Any loose?____________________
- ☐ Any missing?____________________
- ☐ Any chipped or capped?____________________
- ☐ Dental Appliance Type ____________

*(K) CANCER/CHEMOTHERAPY.. NO YES

(L) HEARING AID/GLASSES/PROSTHESIS/CONTACTS ..... NO YES

*(M) OTHER HEALTH PROBLEMS OR SYNDROMES........... NO YES
- Explain ____________________

(N) MENTAL HEALTH PROBLEMS .... NO YES
- Explain ____________________

(O) IS CARETAKER OF PATIENT PREGNANT?.................... NO YES

(P) *Has this child or anyone in your household been diagnosed with VRE, TB, Pertussis or MRSA?............ NO YES*

Informant ______________________________

Phone # ______________________________

Relationship to Child: ______________________________

Date__________________ Time__________________

STAFF ONLY

FORM: ___ Received ___ Complete ___ NOS ___ Problem

Reviewed and cleared by: ______________ Date__________ Time__________

PCP Name______________ Phone #______________ BMI__________