Pediatric Pre-Anesthesia Questionnaire

Date : yy/mm/dd

Name of Child		Date of Birth	yy/mm/dd	Age	
Nickname		Phone Number	Home Phone		
Name of Parent			Work / Cell Phone		

Please complete this form to provide information (regarding your child's medical condition) and give it to the outpatient staff today.

Height: (_____cm) Weight: (_____kg)

Gestational age: _____weeks, Birth weight: _____ grams,

Did your child have any medical issues at birth? YES NO

If YES, what were they? (_____)

e.g. oxygen therapy, mechanical ventilation, surgery, etc.

Has your child been diagnosed with cardiac or lung disease? YES NO

If YES, what was the diagnosis? _____

Does your child wheeze or have difficulty breathing during a cold? YES NO

Has your child been diagnosed with asthma? YES NO

When do the asthma attacks happen? (At random ・ Seasonal ・ Weather ・ Currently not treated ・ Other)

Recent attack : yy/mm/dd _____ Treatment? _____

Does your child snore or occasionally stop breathing while asleep (sleep apnea)? YES NO

Has your child had allergic reactions in the past? YES NO

If YES, what were they? (_____)

Does your child have seizures or lose consciousness? YES NO

Has your child received general anesthesia before? YES NO

At (age_____, for_____surgery. Which hospital? _____)

Were there any abnormal reactions to general or local anesthesia? YES NO

Are there any blood relatives who have had abnormal reactions to general or local anesthesia? YES NO

Other than the above, are there any diseases or problems that have been pointed out/currently treated? YES NO

When and what : _____

Current medications : Name of medicine: _____

Recent Vaccinations : Date: yy/mm/dd _____ Type: _____

Most recent flu or cold symptoms: _____ Months / Weeks / Days ago

Do you have any questions or concerns about anesthesia?

_____

_____

Thank you for your cooperation.

聖路加国際病院麻酔科(2021/03 版)

210312_Ver.2.00_A4 白黒片面

〒104-8560 東京都中央区明石町 9-1 Tel.03-3541-5151 Fax. 03-3544-0649