

SANTA BARBARA SURGERY CENTER

PEDIATRIC HEALTH QUESTIONNAIRE: AGE 12 AND UNDER PAGE 1

This health questionnaire will help us plan the care of your child while at the Santa Barbara Surgery Center. Please return the questionnaire to our center as soon as possible: either by mail or fax (see below). You will receive a phone call from the preop nurse before your surgery date to go over your child's health, answer questions, and to review instructions. Your physician Anesthesiologist will meet with you on the day of surgery to discuss Anesthesia care.

**Your child may have food and liquids according to the following rules.
It is very important for the safety of your child to follow these rules.
Surgery will be cancelled if these rules are not followed.**

- | | |
|--|---|
| <p>1. No solid food after midnight</p> <p>2. Milk or formula up until 6 hours prior to surgery</p> | <p>3. Breast milk until 4 hours prior to surgery</p> <p>4. Clear liquids until 2 hours prior to surgery</p> |
|--|---|
- CLEAR LIQUIDS INCLUDE WATER, CLEAR JUICES, JELLO AND BROTH. NO MILK, ORANGE JUICE OR ANY JUICE WITH PULP!!**

PATIENT'S NAME: _____ PHONE: (home): _____

AGE: _____ DATE OF BIRTH: _____ WEIGHT: _____ HEIGHT: _____

What procedure is planned? _____ SURGEON: _____ SURGERY DATE: _____

YES	NO	Please check the "Yes" or "No" box for each of the following questions. If your answer is "Yes", please circle appropriate response. The questions that follow refer to the patient and his/her medical history unless noted.	
		Have you ever been a patient at Santa Barbara Surgery Center before?	When?
		Have you had previous surgeries?	List:
		Any anesthesia complications?	List:
		Any family with anesthesia problems?	List:
		History of premature birth?	How early?
		Congenital or developmental problems?	Cerebral Palsy / Growth retardation / Other:
		Any heart problems?	Congenital heart disease?
		Any heart procedures or surgeries?	List:
		Dates of heart problems / procedures?	
		Blood pressure problem?	High / Low Taking medications for B/P?
		Lung problems?	Pneumonia / Asthma / Bronchitis / Night time snoring?
		Do you have sleep apnea or heavy snoring?	
		Infectious disease?	Cold / Flu / Cough / Fever / History of Tuberculosis
		Diabetes?	List medications:
		Kidney or bladder problems?	List:
		Liver disease?	Jaundice / Hepatitis
		GastroIntestinal problems?	Reflux / Gastritis / Colic
		Neurologic problems?	Fainting / Seizure / Headache / Muscular Dystrophy
		History of cancer?	Type:
		Significant behavioral problems?	List:

PEDIATRIC HEALTH QUESTIONNAIRE: AGE 12 AND UNDER PAGE 2

PLEASE COMPLETE BOTH SIDES OF THIS FORM

YES	NO	Please check the "Yes" or "No" box for each of the following questions. If your answer is "Yes", please circle appropriate response.	
		Blood or bleeding problems?	Anemia / Poor blood clotting / Too much clotting
		Do you use aspirin or blood thinners?	Last use:
		Thyroid problems?	Hyperthyroid / Hypothyroid
		Dental or jaw problems?	Loose teeth / Trouble opening mouth
		Vision problems?	Cataract / Eyeglasses / Blindness
		Hearing / Language needs?	Hearing Aid / Deafness / Interpreter needed
		Use herbal remedies?	Type:
		Any possibility of pregnancy?	
		Other problems we should know about?	List:

What is the name and phone of your Pediatrician? _____

When was your last checkup? _____

If heart problems, what is the name/phone number of your Cardiologist? _____

When was your last checkup? _____

Name of parents: _____

What are your phone numbers? Cell: _____ Home: _____

Parent/Guardian's Signature

Date/Time

Reviewing RN's Signature

Date/Time

You may mail this form to:

Santa Barbara Surgery Center

3045 De La Vina St.

Santa Barbara, Ca. 93105

TEL: 805-569-3226

You may fax this form to:

1-866-297-5257

This is a secure, private fax machine

We thank you for taking the time to provide us with this important information!