# Pre-Op Screen Patient Form

Le Bonheur Children's Hospital
Methodist Healthcare Family

**Date of Surgery**_____ **Surgeon's Name** _____

**Operation** _____

- Answer **ALL** questions, front and back. Place N.A. (not applicable) by questions if it does not pertain to your child. Please complete form in ink so it will be legible when faxed.
- Call (901) 287-6273, Monday through Friday, between 9 a.m.–5 p.m. if you have a question.
- Surgeon's office will fax this completed form to fax number 901-266-6424.
- Please call the Pre-Op Screening office at 901-287-6273 if your phone numbers change before the surgery date.

## Patient Information

| | | | | |
|---|---|---|---|---|
| Patient's Name | Last | First | M.I. | Name Called |
| Date of Birth | | Age | Sex | Race |
| Cell Phone (mom) Number ( ) | | Cell Phone (dad) Number ( ) | | Cell Phone (other) Number ( ) |
| Work Phone Number ( ) | (Employee Name) ext. # | | Home Phone # | |
| **Name of legal guardian(s)** _____ | | | | |
| Adopted ❑ No ❑ Yes | | If yes, date of final adoption | | |
| Is child in DCS custody? ❑ No ❑ Yes | If yes, list caseworker name & phone #_____ | | | |
| Has your child been exposed to chicken pox, measles, mumps in the last 3 weeks? ❑ No ❑ Yes | | | | |
| Has your child been exposed to or diagnosed with TB? ❑ No ❑ Yes | | | | |
| Has your child been exposed to or diagnosed with HIV? ❑ No ❑ Yes | | | | |
| Have you given your child aspirin, Advil, Motrin (not Tylenol or Tempra) in the last 2 weeks? ❑ No ❑ Yes | | | | |
| Has your child been out of the country in the last 6 months? ❑ No ❑ Yes | | | | |
| Are your child's immunizations (baby shots) up to date? ❑ No ❑ Yes | | | | |

## Anesthesia Information

| | |
|---|---|
| **1** | Did your child have any problems when he/she was born or require a longer than normal hospitalization? ❑ No ❑ Yes If yes, how long? |
| | Was your child born early? ❑ No ❑ Yes Birth weight: |
| | How many weeks did pregnancy last? |
| | Was your child on a machine/respirator to help him/her breathe? ❑ No ❑ Yes If yes, how long? |
| **2** | Please list your child's surgeries and dates performed. _____ None _____ |
| **3** | Please list other procedures performed under general anesthesia. _____ None _____ |
| **4** | Please list your child's hospitalizations and dates admitted. _____ None _____ |

**5** Has your child or family member ever had a problem with anesthesia (such as MH)? ❑ No ❑ Yes
If yes, please explain briefly.

**6** Has your child or family member been diagnosed with muscle disease (such as MD)? ❑ No ❑ Yes
If yes, please explain briefly.

**7** Has your child or family member ever had a bleeding problem? ❑ No ❑ Yes
If yes, please explain briefly.

**8** Does your **CHILD** have any of the following problems? Circle if appropriate and answer each item.
If yes, please list special doctor(s) that follow him/her?

| | | | Doctor |
|---|---|---|---|
| Heart problems (murmurs, irregular beats) | ❑ No | ❑ Yes | _____ |
| Lung problems (asthma, pneumonia, cystic fibrosis, wheezing) | ❑ No | ❑ Yes | _____ |
| Liver problems (jaundice hepatitis) | ❑ No | ❑ Yes | _____ |
| Kidney problems (failure, dialysis) | ❑ No | ❑ Yes | _____ |
| Syndromes | ❑ No | ❑ Yes | _____ |
| Neurological problems (seizures, developmental delay, retardation) | ❑ No | ❑ Yes | _____ |
| Blood disorder (bleeding problems, anemia, sickle cell disease, sickle cell trait) | ❑ No | ❑ Yes | _____ |
| Frequent vomiting, GI reflux (GERD) | ❑ No | ❑ Yes | _____ |
| Endocrine problems (diabetes, thyroid) | ❑ No | ❑ Yes | _____ |

**9** Please list your child's medications including dosage and frequency taken. (Include over the counter medications)

_____

_____

_____

**10**

| | | | If yes, explain |
|---|---|---|---|
| Does your child have any drug allergies? | ❑ No | ❑ Yes | _____ |
| Does your child have any food allergies | ❑ No | ❑ Yes | _____ |
| Does your child have any environmental allergies? | ❑ No | ❑ Yes | _____ |
| Does your child have a Latex allergy? | ❑ No | ❑ Yes | _____ |

**11** Does your child have any medical devices/equipment such as monitor, oxygen, ventilator, CPAP, tracheotomy or Gtube?
❑ No ❑ Yes
If yes, please explain. _____

**12** First day of your child's last menstrual period (if applicable). _____

**13** Does your child feed him/herself? ❑ No ❑ Yes
Does your child eat ❑ baby food ❑ table food ❑ Gtube feedings. Please list all special dietary needs.
Include name of formula. _____

_____

| Completed by: | Relationship to patient: | Date: |
|---|---|---|
| | | |