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.

1. **No solid food after midnight**
2. **Milk or formula up until 6 hours prior to surgery**
3. **Breast milk until 4 hours prior to surgery**
4. **Clear liquids until 2 hours prior to surgery**

***NOTE*: CLEAR LIQUIDS = WATER ONLY**

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:
		Neurologic problems?	Fainting / Seizure / Headache / Muscular Dystrophy
		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?
		Respiratory problems?	Pneumonia / Night time dry cough / Bronchitis / Asthma / Rhinitis
			Wheezing during exercise / Wheezing more than 3x in the last 12 mo.
		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
		History of cancer?	Type:

PEDIATRIC HEALTH QUESTIONNAIRE: AGE 12 AND UNDER PAGE 2

PLEASE COMPLETE BOTH PAGES 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.	
		Significant behavioral problems?	List:
		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: _____

Pharmacy Name & Location? _____

_____ _____

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!

Medication Reconciliation

(Including prescriptions, over the counter medications, herbals, vitamins/minerals and birth control pills/patches)

Allergies	Type of Reaction Noted

Medication Name	Dose*	Frequency* *(how often?)*	Last Taken (Complete the day of surgery)	Instructions

❑ Patient unable to give detailed information. Reason: _____

Obtained from: ❑ Patient ❑ Spouse ❑ SO ❑ Prior Chart ❑ Other _____

POST SURGERY

New Prescriptions	Dose	Frequency *(how often?)*	Reason for taking	Last Taken *(if applicable)*	Instructions	Next dose to be taken at *(after discharge)*
❑ None						

❑ Copy given to patient with discharge instructions

Nurse Signature: _____ Date: _____ Time: _____

patient name