



Pediatric Anesthesia Intake Form

1. Does your child have a history of complications or reactions to anesthesia? (If yes, please explain.)

No Yes *Explanation:* _____

2. Is there a family history of difficulty or complications with Anesthesia? No Yes

3. Does the patient have any known drug allergies? No Yes

4. Does the patient have any medical issues? Please list any. No Yes *Details:*

5. Has your child seen a doctor for anything other than routine physical exams? No Yes

6. Does your child see (or have they ever seen) any specialist doctors? (If yes, please check all that apply)

Cardiology Pulmonology Neurology Urology Psychiatrist/Psychologist Development Doctor Ear/Nose/Throat (ENT) Dermatology (skin) Endocrinology Hematology (blood disorder) Oncology (cancer) Other NONE

7. Please check the box if your child has any of the following (Include severity/explanation):

Heart murmur Congenital heart defect Asthma Autism, ADHD, Developmental Delay, or Cerebral Palsy Easy bleeding, bruising, sickle cell disease, or other blood disorders Diabetes, thyroid problems, or other endocrine condition Heartburn (GERD) Cancer history Genetic syndromes (Trisomy 21, or other) NONE

8. Has your child ever had surgery and/or anesthesia? If yes, please list type and year.

9. Does your child snore or have sleep apnea? No Yes

10. Has your child had a cough or cold symptoms now or in the last 2 weeks? No Yes

11. Has your child ever stayed overnight in the hospital? If yes, for what reason?

12. Has your child ever had to visit the ER (Emergency Room)? For what reason and when?

13. Was your child born full term? No Yes

14. Does your child have any allergies to medications or food? If yes, please list. No Yes *List:*

15. Does your child take any medications regularly? Please list. No Yes *List:*

16. Height and Weight Height (indicate **inches** or **cm**): _____ Weight (indicate **lbs.** or **Kg.**): _____