PREADMISSION MEDICAL ASSESSMENT

IN ORDER TO ENSURE THE BEST POSSIBLE CARE FOR YOUR CHILD, PLEASE COMPLETE THE FOLLOWING PREADMISSION ASSESSMENT. THIS WILL ASSIST THE NURSING AND ANESTHESIA STAFF THAT WILL BE CARING FOR YOUR CHILD.

CHILD'S NAME: ____________________________________ Nickname ____________________ ☐ Male ☐ Female
Date of Birth __________ Height __________________ Weight _______________________

Primary Care Physician Name ______________________ **phone number** ______________________

ALLERGIES ☐ No Known Allergies ☐ Seasonal/Environmental (pollen, etc) ☐ Tape ☐ Latex ☐ Medications Please list allergy and reaction _______________________ ______________________________
MEDICATIONS ☐ None taken ☐ Takes Medications(List Dosage, Frequency, and why med is taken)- Include any over the counter medication and vitamins)
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____
____
____

PREVIOUS SURGERIES HOSPITALIZATIONS (include dates & procedure done if applicable) ☐ No surgery/hospitalization
☐ Had the following completed/was hospitalized for the following
____
____
____

ANESTHESIA PROBLEMS: Has the child or anyone in the family been diagnosed with the following:
☐ Malignant Hyperthermia ☐ Pseudocholinesterase Disease ☐ Severe Postop Nausea/Vomiting

Does the child have/use any of the following ☐ Glasses ☐ Hearing Aids (please circle) Left Right
☐ Loose/Capped/Missing Teeth (please circle) Upper Lower

Is the child exposed to second hand smoke ☐ yes ☐ no **Is there any illicit drug use in the family** ☐ yes ☐no

Is there any alcohol abuse in the family ☐ yes ☐no **Is there any history of physical abuse in the family** ☐ yes ☐no

Does the child suffer from the following:
Hematological System ☐ No Problem with blood diseases ☐ Blood diseases __________ ☐ HIV/AIDS ☐Bleeding tendencies/Factor deficiencies WHICH FACTOR? ___________ ☐ Anemia TYPE? _______________ ☐ History Transfusions
☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** ____
____

Respiratory System ☐ No Problems with Lungs ☐ Asthma ☐ Emphysema ☐ Bronchitis ☐ TB ☐ Sleep Apnea ☐ Other
PLEASE DESCRIBE FURTHER ANY CHECKED : ____
____

Cardiovascular System ☐ No problem with Heart ☐High blood pressure ☐ problem with heart rhythm ☐ Pacemaker ☐Defibrillator ☐ Stroke ☐ Mitral Valve Prolapse ☐ Murmur ☐Phlebitis ☐ problem with heart valves ☐ congenital heart defect now or at birth ☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** ________________________________
____

Nervous System ☐ Denies issues ☐ Seizures ☐ Tremors ☐ Vertigo ☐ Other
PLEASE DESCRIBE FURTHER ANY CHECKED: ____
____

Endocrine System ☐ Denies Issues ☐ Diabetes ☐ Noninsulin Dependent ☐ Insulin Dependent ☐ Thyroid Disease
☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** ____
____

Digestive System ☐ Denies Issues ☐ Hiatal Hernia ☐ Acid Reflux ☐ Ulcers ☐ Hepatitis ☐ Chronic constipation
☐ Chronic Diarrhea ☐ No bowel control ☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** ________________
____

Genitourinary System ☐ Denies Issues ☐ Kidney problems ☐Bladder Issues ☐ Bed Wetter ☐ Other
PLEASE DESCRIBE FURTHER ANY CHECKED: ____

Reproductive System ☐ Denies Issues ☐ Last Menstrual Period ____________ ☐ Not applicable ☐ Ovarian cysts
☐ Endometriosis ☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** ______________________________

Skeletal System ☐ Denies Issues ☐ Arthritis ☐ Neck/Back Problems ☐Limitations in mobility ☐ Wheelchair Bound
☐Other assistive device __________ ☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** ________________
____

Psychosocial ☐ Denies Issues ☐ Mental health disorder ☐ Sleep disorder ☐ recent life changes/stressors ☐ late sleeper
☐heavy sleeper ☐ other **PLEASE DESCRIBE FURTHER ANY CHECKED:** ______________________________
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Skin ☐ Denies Issues ☐ Psoriasis ☐Eczema ☐Bruises ☐ Other **PLEASE DESCRIBE FURTHER ANY CHECKED:** __________
____

Infection ☐ Denies Issues ☐ MRSA ☐ VRE ☐ CDIFF When? ____________ Last test performed? ____________
When? ______________ Where? ________________

Other ☐ Denies ☐ Cancer ☐ Recent illness ☐ Congenital Anomaly ☐ Other
PLEASE DESCRIBE FURTHER ANY CHECKED: ____
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THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. WE LOOK FORWARD TO CARING FOR YOU CHILD.

OFFICE: PLEASE FAX TO (717) 481-4815 UPON COMPLETION. Thank you,