



PLEASE ANSWER THE FOLLOWING QUESTIONS PRIOR TO SCHEDULING PROCEDURE:

Does the Patient have a Cardiac Defibrillator, Narcolepsy, ACTIVE MRSA, Strep, Chicken Pox, or Shingles?	YES	NO
Does the Patient or any family member have a history of Malignant Hyperthermia?	YES	NO

If patient answers "YES" to any of the above questions, the procedure should either be postponed due to infection control issues or the procedure should be performed in the hospital for safety reasons.

YES	NO	PEDIATRIC HEALTH HISTORY/SUMMARY LIST
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- 1. Is there a history of MRSA? *If YES, please have Physician order two Nose Cultures today that are 48-72 hours apart. Both Cultures must be Negative.*
- 2. Was patient born Full Term? If not, Premature Birth @ _____ weeks.
(Required question for patients 6 years and under). N/A

- 3. Are there any Congenital Heart Defects/Conditions or Arrhythmia?

Comments: _____

- 4. Is there a history of Asthma/Reactive Airway/Bronchitis/RSV/Pneumonia/Chronic Cough?

Date of last Episode: _____ Inhaler Nebulizer Treatment Sleep Apnea

- 5. Exposure to Communicable Disease in the last (2) weeks? **Immunizations are Current**

- 6. Is there a history of Diabetes/Hepatitis/GERD?

Comments: _____

- 7. Is there a history of Developmental Delay/Cognitive/Learning Disabilities/Autism?

Cerebral Palsy Cystic Fibrosis Seizure Disorder Anxiety/Depression

Comments: _____

- 8. Is there a history of Drugs/Alcohol/Smoking? **N/A**

- 9. Does the patient have Loose teeth/Braces/Retainer or any other Appliance in the mouth?

- 10. Female Patients Only: Date of LMP _____ **N/A**

- 11. Do you have any blood disorders such as Anemia, Leukemia, or Sickle Cell Anemia?

- 12. List all Allergies and Reactions **N/A**

Comments: _____

- 13. Are there any other Medical Problems/Conditions?

Comments: _____

Height _____ Weight _____ Date of Birth _____ BMI _____

Person Interviewed _____



YES	NO	SURGICAL/ANESTHESIA HISTORY
<input type="checkbox"/>	<input type="checkbox"/>	Has the Patient ever had Anesthesia? Complications PONV N/A Family History with Anesthesia Complications N/A Comments: _____
<input type="checkbox"/>	<input type="checkbox"/>	Has the Patient ever had Surgery? Check all that apply: Appendectomy Arthroscopy BMT Eye Surgery ORIF T&A Other Comments: _____

PRE-OP INSTRUCTIONS

Location of ARSC, directions given if needed.
 We will call you the day before the procedure to give you a confirmed arrival time.
 Nothing to eat or drink after midnight the night before surgery (not even sips of water, candy, gum).
 A parent or guardian must be in the facility at all times. Who are the legal Guardians?
 Name: _____ Name: _____

Are the Legal Guardians the parents? Yes No
 What is the Primary Language spoken at home? English Spanish Other _____
 Is an Interpreter needed? Yes No
 No more than (2) may accompany the patient here at the Surgery Center (usually the parents). No small children please.
 Bring a copy of the Insurance card and a Photo ID.
 For young Pediatric patients, please bring a blanket/stuffed animal or other comfort item. The patient may wear **Clean Pajamas**. A **Bottle** or **Sippy Cup** may be brought for the patient if required after surgery.
 For older Pediatric patients, all jewelry must be removed and left at home. Leave valuables such as a cell phone, wallet/purse at home or locked in car.
 If the patient wears glasses or contacts, they must be removed prior to surgery so please bring a case for them.
 Are there any Cultural or Religious Preferences we should honor while you're here? Yes No
 Comments: _____
 Disclosure of Physician Financial Interest, Patient Rights and Responsibilities, Advanced Directive.

To the best of my knowledge, all medical information is accurate and complete. I realize that withholding information may impact my outcome negatively.

SIGNATURE OF PATIENT/GUARDIAN **DATE**

SIGNATURE OF PRE-OP RN/ARSC **DATE**