

Dr. Gino Gizzarelli*

BScPhm, DDS, MSc (Dental Anaesthesia)

ANAESTHESIA for DENTISTRY

(416) 839-4777

Pre-Anaesthesia Questionnaire (Child)

Date of Birth: _____

Name _____	Date _____	Yes	No	Not sure
1. Does your child have any health problems or concerns presently? Please explain: _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has there been ANY change in general health in the past year? When did your child last visit their family physician? (month)____(year)____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has your child ever been in hospital for treatment? _____ When, where and why? _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has your child ever had general anaesthesia or surgery? _____ When, where and why? _____ Were there any problems with the anaesthesia? _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you or any of your family relatives had problems with anaesthesia? Please explain Were any tests done?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does your child have a drug allergy? What drug? What year? What happened? (Circle) rash breathing problems/wheezing swelling		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Does your child have any other allergies (e.g. latex)? _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Does your child take ANY medications right now (including puffers)? Please list: Name Dose		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Does your child take ANY non-prescription remedies (including herbal remedies)? Name		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has your child had a cortisone (steroid) type drug orally in the past year? When? For how long?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Has your child taken any medicine for a long time in the past? Name Reason		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has your child had aspirin or aspirin containing compounds (ASA, Bufferin, Anacin, 222) within the last week?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Does your child or anyone in the family have a bleeding problem?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Has your child been exposed to any infectious diseases in the past month?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Does your child have any difficulty breathing while sleeping at home?		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>