CHU de Québec
Université Laval

PREOPERATIVE PATIENT QUESTIONNAIRE
0-18 YEARS OLD

To be completed by patients aged 14 and over or by parents if patient is less than 14 years old

PLEASE COMPLETE AND RETURN THIS QUESTIONNAIRE AS SOON AS POSSIBLE TO AVOID ANY DELAY IN YOUR SURGERY

☐ **CHUL**
Preoperative Clinic, G-1238
Fax : 418 654-2115

☐ **L'Hôtel-Dieu de Québec**
Preoperative Unit
Fax : 418 691-5437

☐ **Hôpital Saint-François d'Assise**
Intake Unit C3-620
Fax : 418 525-4313

☐ **Hôpital de l'Enfant-Jésus**
Preoperative Clinic, J-2000
Fax : 418 649-5675

☐ **Hôpital du Saint-Sacrement**
Preoperative Clinic, K-304
Fax : 418 682-7732
Preoperative Clinic, Centre universitaire d'ophtalmologie (CUO)
Fax : 418 682-7578

Surgeon: ____ Proposed surgery: ____

If your child was born prematurely and is less than 5 years old specify number of weeks at birth: _________

Age: _______________ Gender: ☐ M ☐ F Weight: ______ kg or ______ pounds Height: ______ m

Assessed by nurse: BMI: ______ kg/m^2 BP: _________ mmHg Pulse: ______ /min RR : ______ /min Saturation: ______%

Allergie(s): ☐ No ☐ Yes, specify: __________________________________ Reaction: __________________________________

Drug intolerance(s): ☐ No ☐ Yes, specify: ___________________________ Reaction: __________________________________

Medical history (Health problems): ____

Please list all of the prescribed or non-prescribed medication he is taking, including insulin, aerosol, supplements, acetylsalicylic acid (Aspirin), etc. :____

____

In order to lighten the text, the questions are addressed to the parents instead of the patient.

ANESTHESIA	No	Yes	Specify
1. Has your child ever had a general anesthesia (been put to sleep)?	☐	☐	☐ Surgery ☐ Examination
2. Has he/she ever had any problems with anesthesia?	☐	☐	
3. Have any members of your family ever had any adverse reactions to anesthesia?	☐	☐	
4. Does your child have any loose or brittle tooth, tooth crowns or dental implants?	☐	☐	
5. Does he/she have problems moving his/her neck or opening his/her mouth? Does he/she have spinal cord problems? Does he/she suffer from arthritist, arthrosis or ankylosing spondylitis? If so, specify the location and the limitations.	☐	☐	__________________________

RESPIRATORY SYSTEM	No	Yes	Specify
1. Is your child under the care of a respirologist?	☐	☐	Name: ____________________
2. Does he/she have respiratory problems? ☐ Asthma ☐ Bronchitis ☐ Recent lung infection ☐ Sleep apnea (diagnosed by a doctor)	☐	☐	
3. Does your child snore loud enough to be heard through a closed door?	☐	☐	
4. Has anyone observed that your child gasps or stops breathing during sleep?	☐	☐	

Nom : Prénom : # Dossier :

CARDIAC SYSTEM	No	Yes	Specify
1. Is your child under the care of a cardiologist?	☐	☐	Name: __________________
2. Does he/she have heart problems? ☐ Heart murmur ☐ Cardiac valves problems ☐ Arrhythmia ☐ Congenital abnormaly: ______________ ☐ Other: _____________	☐	☐	
3. Does he have a pacemaker? **If so, when and where was it last checked?** Date:_________________ Location:____	☐	☐	
MUSCULAR AND NEUROLOGICAL SYSTEMS	**No**	**Yes**	**Specify**
1. Is your child under the care of a neurologist?	☐	☐	Name: __________________
2. Does he/she have muscular or neurological problems? ☐ Spina bifida ☐ Epilepsy/seizures ☐ Paralysis ☐ Cerebral palsy ☐ Hypotonia ☐ Ataxia ☐ Muscular dystrophy ☐ Developmental delay: _________________________________	☐	☐	
RENAL SYSTEM	**No**	**Yes**	**Specify**
1. Is your child under the care of a nephrologist?	☐	☐	Name: __________________
2. Has he/she ever had renal problems? ☐ Infections ☐ Renal failure	☐	☐	
ENDOCRINOLOGY	**No**	**Yes**	**Specify**
1. Is your child under the care of an endocrinologist or an internist?	☐	☐	Name: __________________
2. Does he/she suffer from diabetes? ☐ Insulin	☐	☐	
3. Does he/she have problems with his/her thyroid gland?	☐	☐	
4. Has he/she taken corticosteroid pills (e.g., prednisone-cortisone) for more than 3 weeks in the past 6 months?	☐	☐	
HEMATOLOGY	**No**	**Yes**	**Specify**
1. Is your child under the care of a hematologist (blood specialist)?	☐	☐	Name: __________________
2. Has he/she ever experienced abnormal bleeding episodes while at the dentist, from minor wounds or from surgeries?	☐	☐	
3. Does he/she suffer from anemia? Does he/she have a personal or family history of thalassemia or sickle-cell anemia? If so, specify: _______________________________	☐	☐	
4. Does he/she have hereditary coagulation disorders? ☐ Von Willebrand ☐ Hemophilia ☐ Leiden ☐ Other	☐	☐	
5. If absolutely necessary, would you refuse a blood transfusion?	☐	☐	If so, specify:
6. Has your child ever had a blood or blood product transfusion?	☐	☐	
7. Has he/she ever had an abnormal reaction to blood products?	☐	☐	If so, specify:
DIGESTIVE SYSTEM	**No**	**Yes**	**Specify**
1. Is your child under the care of a gastroenterologist?	☐	☐	Name: __________________
2. Does he/she suffer from gastric reflux?	☐	☐	
MISCELLANEOUS	**No**	**Yes**	**Specify**
1. Does your child use?: ☐ Alcohol ☐ Drugs ☐ Tobacco	☐	☐	
2. (Girls only) Has she begun menstruating? If so, at what age? _______ years	☐	☐	
3. (Girls only) Is there any chance she could be pregnant?	☐	☐	
4. Has your child been exposed to or in contact with a contagious disease? ______________	☐	☐	
5. Is he/she a carrier of multi-resistant bacteria or chronic infectious diseases? (MSRA, VRE, Hepatitis, HIV, etc.)? ____	☐	☐	
6. Does he/she suffer from a physical disability? ☐ Mobility problems ☐ Deafness ☐ Blindness or significant loss of vision ☐ Other: ________________________________	☐	☐	

Signature of patient or respondent: ____ Date: (yyyy/mm/dd) _______/_____/_____

Name of respondent, if applicable: ____________________________ Relationship: ____________ Phone: __________________

Validation of the questionnaire by nurse: ____ Date: (yyyy/mm/dd) ______/_____/_____

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