BEND SURGERY
C • E • N • T • E • R
In for Care • Home for Comfort

1303 NE Cushing Drive, Suite 200
Bend, Oregon 97701
Phone (541) 318-0858
Fax (541) 318-6740

PEDIATRIC PRE-OPERATIVE QUESTIONNAIRE & EVALUATION

Procedure Date _____

Child's Name _____ DOB _____ Surgeon: _____

Procedure: _____ Pediatrician: _____

Parent email address: _____ Height _____ Weight _____

Does your child see any specialists? (Name / specialty) _____

Parent / Guardian / Caregiver Name(s): _____

Durable Power of Attorney for Health Care? No ❑ Yes ❑ (Please bring a copy)

Phone # _____ (H) _____ (C) _____

Best Phone number to reach you the day of procedure _____ the day before _____

Person accompanying child home _____ Relationship _____ Phone _____

May we leave medical information on your answering machine? No ❑ Yes ❑ _____ Learning Preference - Written / Verbal

Bend Surgery Center may speak to this person about patient's healthcare _____

Please answer the following questions:

	YES	NO	
1.	❑	❑	Was your child born Prematurely? How premature? _____
2.	❑	❑	Have they had asthma, lung disease, exposure to tuberculosis? _____ When _____
3.	❑	❑	Have they had RSV (respiratory syncytial virus), pneumonia, runny nose, frequent colds/cough _____ Date of last cold? _____
4.	❑	❑	Have they had flu, fever, or exposure to infectious diseases (chicken pox, measles) in the last month? When _____
5.	❑	❑	Have they had snoring, sleep apnea (periods of not breathing while asleep) _____
6.	❑	❑	Have they had heart disease, murmurs, blue spells, birth defects? _____
7.	❑	❑	Have they had gastric reflux, or frequent vomiting or other GI problems? _____
8.	❑	❑	Have they had liver disease (jaundice or hepatitis), kidney disease? _____
9.	❑	❑	Do they have Diabetes? _____
10.	❑	❑	Does your child have developmental delays or learning disabilities? Comments: _____ Level of function? _____
11.	❑	❑	Do they have muscle disease or weakness? Where? _____
12.	❑	❑	Have they or blood relative ever had problems with anesthesia or sedation? List Problem _____
13.	❑	❑	Does your child have loose teeth / braces / orthodontic appliances? *(Circle any that apply)*
14.	❑	❑	Other medical problems or comments? _____
15.	❑	❑	Do you have any cultural/religious beliefs that might affect our providing healthcare? _____ Explain: _____

Females: When did patient start her menstrual periods? _____

List all surgeries/hospitalizations your child has had:	Approx. Year	List all surgeries/hospitalizations your child has had:	Approx. Year

History Information Obtained from ❑ Parent ❑ Other _____

Interpreter Utilized ❑ No ❑ Yes Name _____

Parent / Guardian Signature _____ Date _____

X _____ R.N. _____ _____
(Nurse's Signature) (Date) (Time)

PATIENT LABEL HERE