APASS Patient Questionnaire

Children's of Alabama
**1600 7th Avenue South**
**Birmingham, AL 35233**

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

**APASS PRE-ANESTHESIA QUESTIONNAIRE**

| | |
|---|---|
| | **Today's Date** |
| **PATIENT NAME** | **DOB** |
| **Surgeon(s)** | **Date of Surgery** |
| Parent/Legal Guardian Name(s) | Parent/Legal Guardian(s) Phone #s -with area code |
| Primary Care Provider | PCP Phone # -with area code |
| Specialty Provider(s) | |
| **If patient is in DHR custody, please include contact info.**<br>DHR County:_____<br>DHR Caseworker:_____ | DHR Caseworker's Phone #s -with area code |

| | | | |
|---|---|---|---|
| **ALLERGIES** | ☐ NO known allergies | ☐ YES → | **List ALL food, drug and latex (rubber) allergies.** |
| **Current Home Medications** | ☐ NO home meds | ☐ YES → | **List ALL home over-the counter, herbal, essential oils, complementary and alternative medications.** |
| **Prior Operations** | ☐ NO previous surgery | ☐ YES → | **List all surgeries or anesthesia procedures.** |

| | | | |
|---|---|---|---|
| Has the PATIENT ever had problems with anesthesia (severe nausea & vomiting, difficult to intubate, Malignant Hyperthermia [MH], Pseudocholinesterase Deficiency, etc.)? | ☐ NO | ☐YES→ | **If YES to any below, please explain.** |
| Does the PATIENT have a muscle disease (Muscular Dystrophy), bleeding disorder (Hemophilia, Von Willebrand Disease) or blood disorder (Sickle Cell Trait, Sickle Cell Anemia, Thalassemia)? | ☐ NO | ☐YES→ | |
| Does the PATIENT have problems opening the mouth or moving/turning the neck or head? | ☐ NO | ☐YES→ | |
| Have any FAMILY members had problems with anesthesia? | ☐ NO | ☐YES→ | |
| Do any FAMILY members have a muscle disease or bleeding/blood disorder? | ☐ NO | ☐YES→ | |

| | | | |
|---|---|---|---|
| Birth Hospital | Birth Weight<br>_____ lb, _____oz | ☐Full Term (≥37 wk)<br>☐Premature (<37 wk) | ☐Twin<br>☐Triplet |
| How long did the patient stay in the hospital @ birth? | How many weeks & days gestation was the patient when born?<br>_____weeks _____days | ☐ Neonatal Jaundice<br>☐ NICU @ birth<br>☐ Oxygen @ birth<br>☐ Ventilator @ birth | **List birth complications.** |

APASS Patient Questionnaire

Children's of Alabama
**1600 7th Avenue South**
**Birmingham, AL 35233**

Patient Name: _____

Date of Birth: _____

Medical Record Number: _____

**APASS PRE-ANESTHESIA QUESTIONNAIRE** (page 2)

| **PATIENT Name** | **DOB** |
|---|---|
| **Name of Person Completing Form: _____** | |

| | | | |
|---|---|---|---|
| Has the patient had a cold or stomach virus in the last 1-2 weeks? | ☐ NO | ☐ YES → | **If YES to any below, please explain.** |
| Has the patient had COVID-19, bronchitis, croup, pneumonia or flu in the last 4-6 weeks? | ☐ NO | ☐ YES → | |
| Has anyone living in the patient's house had COVID-19 in the last 4 weeks (or are they awaiting COVID-19 test results)? | ☐ NO | ☐ YES → | |
| Has the patient taken steroids in the last 6 weeks? (Do not include daily inhaled steroids.) | ☐ NO | ☐ YES → | |
| Has the patient been seen in the ER or admitted to the hospital in the last 3 months? | ☐ NO | ☐ YES → | |

| | | | |
|---|---|---|---|
| Does the patient have any implantable metal devices? | ☐ NO | ☐YES→ | ☐baclofen pump ☐cochlear implant ☐dental braces<br>☐bone anchored hearing aid (BAHA) ☐dental retainer<br>☐pacemaker ☐vagal nerve stimulator (VNS)<br>☐OTHER METAL DEVICE:_____ |
| Does the patient use home medical equipment? | ☐ NO | ☐YES→ | ☐apnea monitor ☐BiPAP ☐CPAP ☐Oxygen ☐insulin pump<br>☐continuous glucose monitor ☐feeding tube ☐ventilator<br>☐Oxygen saturation monitor ☐tracheostomy (SIZE:_____) |
| Does the patient have an impairment, developmental delay, genetic condition or syndrome? | ☐ NO | ☐YES→ | ☐autism ☐blind ☐cerebral palsy (CP) ☐contact lenses<br>☐developmental delay ☐Down Syndrome ☐eye glasses<br>☐hearing loss ☐hearing aid(s) ☐non-verbal<br>☐speech delay ☐ wheelchair bound ☐uses a walker<br>☐OTHER SYNDROME/CONDITION:_____ |
| Does the patient have a learning or psychiatric condition? | ☐ NO | ☐YES→ | ☐ ADD ☐ ADHD<br>☐ anxiety ☐ depression<br>☐previous suicide attempt (WHEN:_____)<br>☐OTHER LEARNING/PSYCHIATRIC CONDITION:_____ |
| Does the patient use alcohol, tobacco or recreational drugs? | ☐ NO | ☐YES→ | ☐alcohol ☐anabolic steroids ☐dips/chews tobacco<br>☐marijuana ☐recreational drugs ☐smokes cigarettes ☐ vapes<br>☐OTHER:_____ |
| Does the patient have body piercings? | ☐ NO | ☐YES→ | ☐ear(s) ☐lip ☐nose ☐tongue ☐naval<br>☐OTHER PIERCINGS:_____ |
| Does the patient have past or present medical conditions? | ☐ NO major medical history | ☐YES→ | ☐broken teeth ☐capped teeth ☐ loose teeth ☐asthma<br>☐airway abnormality ☐blood transfusion ☐cancer ☐diabetes<br>☐cervical spine injury ☐gastroesophageal reflux (GERD)<br>☐heart condition ☐heart murmur ☐hepatitis ☐jaundice<br>☐ high blood pressure ☐kidney disease ☐liver disease ☐MRSA<br>☐ seizures ☐ sleep apnea ☐thyroid condition ☐ VP shunt<br>☐traumatic brain injury ☐tuberculosis (TB) ☐wheezing<br>☐OTHER MEDICAL CONDITIONS:_____ |