ANESTHESIA PRE-ADMIT SCREENING SERVICE (APASS)

PRE- ANESTHESIA PATIENT QUESTIONNAIRE

Patient's FULL LEGAL Name (first, middle & last name)	**Patient's Date of Birth**	**Patient's Nickname (if applicable)**
Procedure(s)	**Date of Procedure**	**Surgeon/Ordering Provider(s)**

Mother's Name	Father's Name
Mother's Home Number ( )	Father's Home Number ( )
Mother's Cell Number ( )	Father's Cell Number ( )
Mother's Work Number ( )	Father's Work Number ( )
Mother's Other Number ( )	Father's Other Number ( )

If the patient's legal guardian is different than the patient's mother/father, please list.	Patient's LEGAL GUARDIAN Name(s)	Legal Guardian's Relationship to Patient
If the patient is in (DHR) Department of Human Resources custody, please provide DHR case worker contact info.	Name of DHR Case Worker DHR County:	DHR Case Worker Contact Number(s) Office ( ) Cell ( )

(Please complete if your child has EVER seen a specialty physician/provider.)

SPECIALTY	SPECIALTY PROVIDER'S NAME	SPECIALTY	SPECIALTY PROVIDER'S NAME
Cardiology		Neurology	
Endocrinology		Pulmonary	
Hematology/Oncology		Other Specialty	

Patient's Pediatrician or Primary Care Provider (PCP)	Pediatrician or PCP's Office Number ( )	Pediatrician or PCP's City & State

MEDICATION HISTORY □The PATIENT DOES NOT TAKE daily or as needed home MEDICATIONS, inhalers/aerosols, vitamins or non-traditional/herbal supplements.

PATIENT'S MEDICATIONS _____

Are there any cultural or religious beliefs that we need to know about to take care of your child? (ex: NO blood products)	□ NO □ YES-Please explain

Date Form Was Completed	Person Completing APASS Form	Relationship to Patient

APASS PRE- ANESTHESIA PATIENT QUESTIONNAIRE

Patient's Name:
Patient's DOB:

ALLERGY STATUS

TYPE OF PATIENT ALLERGY	MEDICATION OR SUBSTANCE THAT CAUSED THE PATIENT'S ALLERGIC REACTION AND REACTION (if applicable)	TYPE OF PATIENT ALLERGY	MEDICATION OR SUBSTANCE THAT CAUSED THE PATIENT'S ALLERGIC REACTION AND REACTION (if applicable)
LATEX ALLERGY □ NO □ YES		**FOOD ALLERGY** □ NO □ YES	
DRUG ALLERGY □ NO □ YES		**OTHER ALLERGY** □ NO □ YES	

FAMILY HISTORY (BIOLOGICAL MOTHER AND FATHER'S FAMILY)

FAMILY HISTORY OF PROBLEMS WITH ANESTHESIA (EX: MALIGNANT HYPERTHERMIA, Pseudocholinesterase Deficiency, etc.) □ NO □ YES-Please explain the family members relationship to the patient and reaction with anesthesia:	**FAMILY HISTORY OF MUSCLE DISORDERS** (EX: MUSCULAR DYSTROPHY, Myopathy, Central Core Disease, Multiminicore Disease, etc.) □ NO □ YES-Please explain the family members relationship to the patient and type of muscle disorder:
FAMILY HISTORY OF BLEEDING DISORDERS (EX: HEMOPHILIA, Von Willebrand Disease, Factor V Leiden, etc.) □ NO □ YES-Please explain the family members relationship to the patient and type of bleeding disorder:	**FAMILY HISTORY OF SICKLE CELL DISEASE/TRAIT OR THALASSEMIA** □ NO □ YES-Please explain the family members relationship to the patient and type of sickle cell disease/trait or thalassemia:

SURGICAL HISTORY

□The PATIENT HAS NEVER HAD SURGERY OR ANESTHESIA in the past.

TYPE OF SURGERY/ ANESTHESIA PROCEDURE	HOSPITAL	YEAR OR AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____

HAS THE PATIENT EVER HAD A REACTION TO ANESTHESIA?

(EX: MALIGNANT HYPERTHERMIA, Pseudocholinesterase Deficiency, reactions to anesthesia medications, trouble placing the breathing tube, irregular heart rhythm/beat, severe nausea/vomiting, trouble breathing, slow to wake up, etc.)

□ NO

□ YES-Please explain. _____

APASS PRE- ANESTHESIA PATIENT QUESTIONNAIRE

Patient's Name:
Patient's DOB:

BIRTH HISTORY

Was the patient born early? □ NO (BORN FULL TERM) □ YES (BORN EARLY)	**(GESTATIONAL AGE) The patient was born at how many weeks or months?**	**How many days, weeks or months was the patient in the hospital at birth?**
BIRTH HOSPITAL	**BIRTH WEIGHT**	**WAS THE PATIENT A TWIN, TRIPLET OR MULTIPLE?** □ NO □ YES-Please explain.
BIRTH COMPLICATIONS □ APNEA □ BREATHING PROBLEMS □VENTILATOR	**BIRTH COMP (CONTINUED)** □ BLOOD TRANSFUSION □ HEART MURMUR □ JAUNDICE	**PLEASE LIST OTHER BIRTH COMPLICATIONS.** _____ _____

RECENT HISTORY

Has the patient been sick with a cold or virus in the last 7 days?	□ NO □ YES-Please explain. Diagnosed with: Date diagnosed:
Has the patient had bronchitis, croup, pneumonia, flu or mononucleosis in the last 6 weeks?	□ NO □ YES-Please explain. Diagnosed with: Date diagnosed:
Has the patient had to take steroids in the last 2 months? (EX: Prednisone, Prednisolone, Orapred, etc.)	□ NO □ YES-Please explain. Diagnosed with: Length of time on steroids: Date of last steroid dose:
Has the patient been seen in an Emergency Department (ED) or been admitted to a hospital in the last 3 months?	□ NO □ YES-Please explain. Diagnosed with: Date seen in the ED? If admitted, dates the patient was in the hospital?
Does the patient have any problems opening their mouth or moving their head/neck?	□ NO □ YES-Please explain.
Does the patient have any loose/broken/capped teeth or wear braces/permanent retainers?	□ NO □ YES-Please explain.
Does the patient wear glasses or contact lenses?	□ NO □ YES-Please explain.
Does the patient have piercings other than the ears?	□ NO □ YES-Please explain.
Has the patient received a blood transfusion/product within the last 3 months?	□ NO □ YES-Please explain. Date of blood transfusion: Reason for blood transfusion:
Does the patient use tobacco products, alcohol or addictive/recreational drugs?	□ NO □ YES-Please explain.
If the patient is FEMALE, has she ever had a menstrual cycle (period)?	□ NO □ YES Date of last cycle:

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Patient's Name:
Patient's DOB:

MEDICAL HISTORY

PATIENT HISTORY	PATIENT HISTORY
GENETIC DISORDERS (SYNDROMES), DEVELOPMENTAL DELAYS , PSYCHIATRIC DISORDERS (EX: Muscular dystrophy, myasthenia gravis, multiple sclerosis, down syndrome, pierre robin, autism, spina bifida, cerebral palsy, depression, anxiety, OCD, etc.) □ NO □ YES-Please explain	**NEUROLOGICAL DISORDERS** (EX: seizures, stroke, ventriculoperitoneal shunt, hydrocephalus, vagal nerve stimulator, etc.) □ NO □ YES-Please explain
LUNG DISORDERS (EX: asthma/reactive airway disease, wheezing, cystic fibrosis, CPAP/BiPAP, bronchopulmonary dysplasia, home ventilator, sleep apnea, home oxygen, apnea monitor) □ NO □ YES-Please explain	**MUSCULOSKELETAL DISORDERS** (EX: bone fracture, scoliosis, torticollis, paralysis, spasticity, hypotonia, cervical spine injury, etc.) □ NO □ YES-Please explain
HEART CONDITION/DISEASE OR BLOOD PRESSURE ISSUES (EX: heart surgery, structural heart condition, murmur, irregular heart rhythm, pacemaker, high/low blood pressure, etc.) □ NO □ YES-Please explain	**KIDNEY DISORDERS** (EX: kidney reflux/disease, dialysis, etc.) □ NO □ YES-Please explain
GASTROINTESTIONAL/LIVER DISORDERS (acid reflux, ulcerative colitis, crohn's disease, aspiration, gastrostomy, failure to thrive, hepatitis, cirrhosis, etc.) □ NO □ YES-Please explain	**ENDOCRINE DISORDERS** (EX: diabetes, hypo/hyperthyroidism, graves disease, etc.) □ NO □ YES-Please explain
ABNORMAL AIRWAY ISSUES (EX: Tracheostomy, stridor, floppy airway, small mouth opening, etc.) □ NO □ YES-Please explain	**BLOOD DISORDERS OR CANCER** (EX: Stem cell transplant, cancer, leukemia, sickle cell disease/trait, thalassemia, von willebrand disease, hemophilia, anemia, etc.) □ NO □ YES-Please explain
CONTAGIOUS ILLNESSES (EX: tuberculosis, MRSA, HIV/AIDS, etc.) □ NO □ YES-Please explain	**ANY OTHER DISORDERS** (EX: organ transplant, cochlear implant, blood transfusion history, immune deficiency, etc.) □ NO □ YES-Please explain

Does the patient have any implantable metallic devices? (Please circle if applicable.)	Cochlear Implant, Implantable Programmable Shunts, Dental Braces/Implants/Permanent Retainers or Hardware, Surgically Implanted Metallic Devices/Hardware

Is there anything else that we should know about the patient in order to take care of them on the date of the procedure? □ NO □ YES-Please explain: