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

Patient Label

ANESTHESIA PRE-ADMIT SCREENING SERVICE (APASS) PRE-OPERATIVE QUESTIONNAIRE

Name of person completing questionnaire:_____ Date:_____

PATIENT LEGAL NAME:_____

NICKNAME:_____ DOB:_____

SURGEON:_____ DATE OF SURGERY:_____

PROCEDURE:_____

Primary care provider (PCP):_____ PCP phone #:_____

Specialty providers:_____

Legal guardian name(s):_____Relationship to patient:_____

Legal guardian phone #s (including area code):_____

If the patient is in DHR custody, please provide DHR contact information.

DHR county:_____ Caseworker's name:_____

Caseworker's phone #s (including area code):_____

ALLERGIES-include all food, drug, and Latex allergies			
HOME MEDICATIONS- include all over-the-counter, herbal, essential oils, complementary and alternative medications			
Has the patient had a cold or virus in the last 1-2 weeks?	NO	YES	(If yes, please provide details.)
Has the patient had bronchitis, croup, pneumonia, or flu in the last 4-6 weeks?	NO	YES	
Has the patient been treated with steroids in the last 6 weeks?	NO	YES	
Has the patient been seen in the ER or admitted to the hospital in the last 3 months?	NO	YES	

PRIOR OPERATIONS-include all anesthesia procedures			

Has the patient ever had problems with anesthesia?	NO	YES	(If yes, please provide details.)
Have you ever been told the patient was difficult to intubate?	NO	YES	
Has the patient ever had a high fever with anesthesia? (Malignant Hyperthermia)	NO	YES	
Does the patient have problems opening the mouth or moving/turning the neck or head?	NO	YES	

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FAMILY HISTORY

Have any family members had problems with anesthesia?	NO	YES	(If yes, please provide details.)
Have any family members had a high fever with anesthesia? (Malignant Hyperthermia)	NO	YES	
Do any family members have a muscle disease? (Muscular Dystrophy)	NO	YES	
Do any family members have a bleeding or blood disorder? (Sickle Cell Trait, Sickle Cell Anemia, Thalassemia, Hemophilia, Von Willebrand Disease)	NO	YES	

MEDICAL HISTORY

Birth hospital		Birth weight	_____lb, ____oz
How long did the patient stay in the hospital at birth?		How many months/weeks/days was the patient when born?	
Full term (≥ 37 weeks)	NO YES	Premature (< 37 weeks)	NO YES

Was the patient on a ventilator at birth?	NO	YES	(If yes, please provide details.)
Was the patient on oxygen at birth?	NO	YES	
Did the patient go home on oxygen at birth?	NO	YES	
Did the patient go home on a monitor at birth?	NO	YES	
Was the patient a twin, triplet, or multiple?	NO	YES	
Did the patient have any birth complications?	NO	YES	

(Please check all that apply to the patient's previous or current medical history.)

____ACID REFLUX
____AIRWAY ABNORMALITY
____AUTISM
____ASTHMA
____BRONCHOPULMONARY DYSPLASIA (BPD)
____CANCER
____CEREBRAL PALSY (CP)
____DEVELOPMENTAL DELAY
____DIABETES
____DOWN SYNDROME
____FEEDING TUBE
___HEART CONDITION
___HEART MURMUR
____HEMOPHILIA
____HIGH BLOOD PRESSURE
____KIDNEY CONDITION
____LIVER CONDITION
____MRSA
____MUSCULAR DYSTROPHY (MD)
____PARALYSIS
____SEIZURES
____SICKLE CELL ANEMIA
____SICKLE CELL TRAIT
____SLEEP APNEA
____ THALASSEMIA
____THYROID CONDITION
____TRACH
____TRANSPLANT
____TUBERCULOSIS (TB)
____WHEEZING
____BIPAP/CPAP
____HOME APNEA MONITOR
____HOME OXYGEN (O2)
____HOME OXYGEN SATURATION MONITOR
____HOME VENT
____ANXIETY
____DEPRESSION
____SUICIDE ATTEMPT
____IMPLANTABLE METAL DEVICE
____BACLOFEN PUMP
____BONE ANCHORED HEARING AID (BAHA)
____COCHLEAR IMPLANT
____PACEMAKER
____VAGAL NERVE STIMULATOR (VNS)

Other patient medical conditions not listed:_____

Check if the patient uses: [ ] Alcohol [ ] Tobacco products [ ] Recreational drugs