CHVR - Preoperative health questionnaire for children - Anglais

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Hôpital du Valais
Spital Wallis

Preoperative assessment clinic (UEP), CHVR

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Please fill in this questionnaire before visiting the preoperative assessment clinic (UEP).

Last name of your child: .....First name : .....

Height : ..... Weight : ..... kg Age : .....years

1. Does your child currently take a treatment for any medical condition? No ☐ Yes ☐
   If so, which one(s) ?

2. If this may concern your child: is she pregnant ? No ☐ Yes ☐

3. Does your child take any drugs or pills ? No ☐ Yes ☐
   If so, please state:

Name of drug / pill	Dose	Morning	Noon	Night

4. Has your child had any surgical interventions done before? No ☐ Yes ☐

   If so, which interventions and when ?

Intervention	Year

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	Yes	No	Do not knom / Remarks
5. Was your child born prematurely? If so, during which week of pregnancy was he/she born?			
6. Has your child had any specific problem during his/her first weeks of life? If so, which one(s)?			
7. Has your child had any medical treatment during the last 6 months? If so, for which kind of illness(es)?			
8. Has your child had any problems with anaesthetic? If so, which one(s)?			
9. Among the child's relatives, do you know of any incident related to an anaesthesia? If so, which one(s)?			
10. Concerning his/her physical abilities, is your child weaker than most children of the same age?			
11. Is there any heart murmur known?			
12. Does your child currently have the flu ? Does your child have a cough? Does your child have a fever?			
13. Does your child have any particular breathing problems when making a physical effort?			
14. Does your child suffer from asthma? If so, does he/she take any medication(s)? If so, which one(s)?			
15. Does your child suffer from any respiratory problem? If so, which one(s)?			
16. Is your child allergic to anything ? If so, to what? (hay fever, food allergies, drug allergies, sticking-plaster, animals…)			
17. Are any particular allergies known in the child's family?			
18. Does your child bleed easily from the nose, or does he/she frequently have hematomas?			
19. Does your child suffer from any neurologic illness? If so, from which one(s)? (for example: epilepsy, paralysis, developmental retardation, etc..)			

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	Yes	No	Do not knom / Remarks
20. Does your child suffer from any neuromuscular disorder or from muscle weakness?			
21. Is your child diabetic? If so, which is his/her daily dose of insuline ?			
22. Does your child have an eye affection? If so, which one(s)?			
23. Does your child have bad teeth? (loose teeth, decay)			
24. Any other details that you would like to mention?			
25. Have you discussed the intervention with your child?			
26. Does your child have a nickname? If so, which one?			
27. **If this questionnaire is filled in on the day of surgery** : When has your child last had anything to drink? Anything to eat?			
28. Have your child or you ever developed anticipated guidelines or named a therapeutic representative?			

Date : ..... Signature of parents : .....