Wesmark Ambulatory Surgery Center
Pediatric Pre-Op Assessment

********Please complete **ALL** questions and return to Wesmark at least **ONE WEEK PRIOR** to procedure/surgery date ********

Today's Date: _____

Patient: _____Patient's Birthday: _____
Person Interviewed: _____Relationship:_____
Legal Custody / Guardian: _____
Best phone number to reach you:_____

Procedure:_____Surgery Date:_____Surgeon:_____
Primary Doctor:_____Phone#:_____

Height:_____Weight:_____Age:_____Male / Female

***Have you been tested for COVID-19: Date tested: _____Results: Positive / Negative**
***Are you currently waiting COVID-19 test results: Yes / No**
Have you been in close contact with anyone who has tested positive: Yes / No

Medications:

Medication	Dose	Frequency	Comments

Allergies / Reactions: (*allergies must have documented reaction or unknown)
Medications:_____
_____
Food:_____
Latex / Suture / Tape / Betadine:_____

Previous Surgeries:_____
_____
_____
Last anesthesia date:_____ Where: _____Problems / Reactions:_____
_____
Family with reactions to anesthesia (explain):_____
_____

Notes / Records Requested:

Health Survey Questionnaire:

1. **Hospital Admissions? Yes / No**

Admission Reason / Dates: _____

_____

2. **Learning or behavioral problems: Yes / No**
   ADD / ADHD / Autism

3. **Difficulty with seeing / hearing / speaking: Yes / No**

4. **Are immunizations up to date: Yes / No**

5. **Recent infection or recent exposure to contagious diseases? Yes / No**
   Chicken pox, measles, mumps, Tuberculosis, flu, hand-foot-mouth, C-Diff, Coronavirus or other:

6. **Birth defects / genetic defects/ premature: Yes / No**

Explain: If premature, how many weeks? _____

7. **Neurological problems: Stroke / Cerebral Palsy / Seizures Yes / No**

Weakness / deficits / Difficulty Swallowing: _____

Last seizure:_____

8. **Heart problems: Yes / No**

HTN(high blood pressure) / murmur / congenital heart defect / taking blood thinners

_____

_____

Cardiologist:_____**Phone #**_____

Last EKG / labs:_____

10. **Require antibiotics before procedures: Yes / No**

_____

11. **Have any breathing problems: Yes / No**

Bronchitis / COPD / asthma / sleep apnea / use CPAP / croup

_____

12. **Does your child or anyone in the house smoke? Yes / No**

Packs per day / years _____

13. **Has your child ever had cancer: Yes / No**

Type / Treatment / When:_____

14. **Does your child have stomach problems: Yes / No**

Ulcer / hernia / GERD (Reflux)

15. **Does your child have kidney disease / diabetes / thyroid disease? Yes / No**
    - **Do you check your blood sugar at home? Yes/No If so how often?**_____

16. **Does your child have liver disease / hepatitis / Tuberculosis / HIV / AIDS? Yes / No**

_____

17. Does your child have any blood disorders? Yes / No
Anemia / Sickle Cell disease

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18. Broken bones? Yes / No
Hardware / Implants

19. Females: Has your daughter started her menses? Yes / No / NA

20. Does your child alcohol / use recreational drugs Yes / No
Type / Frequency:_____

21. Please list any other medical conditions: Yes / No

***REVIEW** all instructions below, **SIGN** at the bottom of the page verifying understanding of the instructions and call with any questions:

1. **Do not eat or drink anything past midnight the night prior to surgery.**
2. **Please bring the following:**
   - **Medications, including inhalers**
   - **Extra diapers, pull ups, or underwear**
   - **Bottles or sippy cups, and formula**
   - **Favorite comfort item (Blanket or stuffed animal; tablets/phones are also allowed)**
3. **You will need someone to drive you home, who will be present during the entire procedure. Limit to one person per adult, two per child.**
4. **Dress comfortably. Do not wear jewelry, lotion, or nail polish.**
5. **Bring all of your medications with you, including inhalers.**
6. **Instruct patient / family to call with any significant changes in medical history or medications.**
7. **Remind patients of child-bearing age: urine pregnancy test will be done morning of procedure.**
8. **Medications to take on morning of surgery with a sip of water:** _____
   (HTN med (high blood pressure), thyroid med, reflux med, cardiac meds) BRING ALL MEDICATIONS TO WESMARK ON DAY OF SURGERY.
9. **Labs ordered:**_____ **Date Drawn:**_____ **Lab:**_____
10. **Remind patient and family members that no firearms or concealed weapons are allowed in the facility.**
11. **State law requires use of a car seat, the driver must have it properly secured before the procedure can take place.**

****ANESTHESIA REVIEW FOR ANY SIGNIFICANT MEDICAL HISTORY****

Patient/Guardian Signature:_____**Date/Time:**_____

RN signature:_____**Date / Time:**_____

Patient Instructions

Please keep for your records

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Please note during the pandemic only the patient and one parent will be allowed in facility.