Dr. Gino Gizzarelli*

BScPhm, DDS, MSc (Dental Anaesthesia)

ANAESTHESIA *for* DENTISTRY

(416) 839-4777

Pre-Anaesthesia Questionnaire (Child) Date of Birth: _____

Name ________________________ Date ______________

		Yes	No	Not sure
1.	Does your child have any health problems or concerns presently? Please explain:____	☐	☐	☐
2.	Has there been ANY change in general health in the past year? When did your child last visit their family physician? (month)_____(year)_____	☐	☐	☐
3.	Has your child ever been in hospital for treatment? ________________________ When, where and why? ____	☐	☐	☐
4.	Has your child ever had general anaesthesia or surgery? ____________________ When, where and why? ____ Were there any problems with the anaesthesia? ____________________________	☐	☐	☐
5.	Have you or any of your family relatives had problems with anaesthesia? Please explain Were any tests done?	☐	☐	☐
6.	Does your child have a drug allergy? What drug? What year? What happened? (Circle) rash breathing problems/wheezing swelling	☐	☐	☐
7.	Does your child have any other allergies (e.g. latex)? ______________________	☐	☐	☐
8.	Does your child take ANY medications right now (including puffers)? Please list: Name Dose	☐	☐	☐
9.	Does your child take ANY non-prescription remedies (including herbal remedies)? Name	☐	☐	☐
10.	Has your child had a cortisone (steroid) type drug orally in the past year? When? For how long?	☐	☐	☐
11.	Has your child taken any medicine for a long time in the past? Name Reason	☐	☐	☐
12.	Has your child had aspirin or aspirin containing compounds (ASA, Bufferin, Anacin, 222) within the last week?	☐	☐	☐
13.	Does your child or anyone in the family have a bleeding problem?	☐	☐	☐
14.	Has your child been exposed to any infectious diseases in the past month?	☐	☐	☐
15.	Does your child have any difficulty breathing while sleeping at home?	☐	☐	☐