Pediatric Pre-Anesthesia Assessment & Anesthesia Planning Sheet
Mackay Memorial Hospital

Name： ☐M ☐F
Chart # Age ：
Ward：

Pediatric Personal History （Filled By Parent）

In order for the anesthesiologist to fully understand your child's health condition and history, please complete this checklist and provide detail information where specified.

1. Is your child born premature? ☐**No** ☐**Yes** → (Born at_____wks)
2. Is your child diagnosed with cardiovascular diseases? ☐**No** ☐**Yes** → (☐ Congenital heart disease ☐Heart Murmur ☐ Arrhythmias ☐Cyanotic when crying ☐Cyanotic at rest/sleeping ☐Others _____)
3. Is your child diagnosed with respiratory diseases? ☐**No** ☐**Yes**→ (☐Asthma☐Pneumonia☐Allergic rhinitis ☐Sinusitis ☐Others_____)
4. Is your child diagnosed with neurological diseases? ☐**No** ☐**Yes**→ (☐ Cerebral palsy ☐Brain injury or concussion☐Brain tumor☐Spine disorders ☐Epilepsy☐Polio☐Others_____)
5. Is your child diagnosed with gastroenteral diseases? ☐**No** ☐**Yes** → (☐Jaundice☐Tracheoesophageal fistula☐Imperforate anus☐ diaphragmatic hernia ☐ Omphalocele or inguinal hernia ☐Others_____)
6. Is your child diagnosed with renal diseases? ☐**No** ☐**Yes**→ (☐Renal tumor☐Abnormal renal function ☐Hemodialysis ☐Others_____)
7. Is your child diagnosed with coagulation or hematological diseases? ☐**No** ☐**Yes**→ (☐Gum or subcutaneous bleeding☐ Thrombocytopenia ☐ Hemophilia ☐ Anemia ☐Leukemia☐Others_____)
8. Has your child taken any medication recently? ☐**No** ☐**Yes**→(☐Steroids ☐Anticonvulsants ☐Antibiotics ☐Hormone drugs ☐Herbal medicine ☐Antihistamines ☐Antineoplastic agents ☐ antithrombotics ☐Others_____)
9. Is your child allergic to any drugs? ☐**No** ☐**Yes**→ (☐ Antibiotics ☐ Anti-inflammatory drugs and pain killers ☐Anesthetics☐Cold medicine ☐Others or unknown_____)
10. Have any of your family members had severe adverse reaction to anesthetics? ☐**No** ☐**Yes**→ (☐Malignant hyperthermia ☐Others_____)
11. Has your child ever had an operation under anesthesia? (If no, jump to 13) ☐**No** ☐**Yes**→(operation: _____)
12. Did your child have any discomfort after anesthesia? ☐**No** ☐**Yes**→☐Nausea/vomiting☐Hoarseness ☐Others_____)
13. Has your child had any of the following conditions for the past two weeks? ☐**No** ☐**Yes**→ (☐Fever ☐Common cold ☐Yellowish nasal discharge ☐Productive cough ☐Vomiting ☐Rash☐Others ___)
14. Does your child have any other congenital disorders? ☐**No** ☐**Yes**→(_____)
15. Is your child's activity limited by shortness of breath easily? ☐**No** ☐**Yes**
16. Does your child have any loose teeth? ☐**No** ☐**Yes**
17. Your child's height: _____ cm, body weight : _____ kg

Signature / date: _____
Relationship:☐Parent ☐Grandparent ☐Others_____

Examination Results and Anesthesia Plans （Filled by Anesthesia Team）

CXR:：☐ Done ☐ Not Done _____
EKG： ☐ Done ☐ Not Done _____
CBC : ☐ Done ☐ Not Done _____
Infectious disease：☐ None ☐ Open TB ☐ HIV ☐ Hepatitis ☐ MRSA
Note：

Airway：☐Normal ☐Limitation of mouth opening ☐Short neck ☐ Stiffness of neck ☐Receding mandible
Teeth：☐normal ☐Abnormal (loose or missing：location _____)
ASA Class 1 2 3 4 5 E
Anesthesia：GA SA EA IVG Block _____
Post-op：Ward ICU Outpatient PCA

Signature of Anesthesiologist：_____，Date: _____