PATIENT HEALTH QUESTIONNAIRE

Patient 's parent/guardian to complete. If help is required ask your family, local doctor or phone _____.

Surname	MRN
Given Name	Male ☐ Female ☐
D.O.B: ____ / _____ / _____	M.O.
Address	
Location/ward	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Patient Name / Known as:	
Who will bring the child to hospital? (Name):	
Relationship to child:	
Phone:	
Are they the legal guardian? No ☐ Yes ☐	

Office use only

Age:	
Weight:	
Height:	
Planned procedure:	

Are you (is the person) of Aboriginal or Torres Strait Islander origin? No ☐ Yes, Aboriginal ☐ Yes, Torres Strait Islander ☐ Yes, both Aboriginal and Torres Strait Islander ☐

Please tick the applicable box/es and add any necessary details in the space provided. Where there is not enough space, please tick the box and attach the additional information sheet.

1. Was your child born prematurely? No ☐ Yes ☐ How many weeks?
2. Does your child have any health problems other than your planned procedure/surgery? If yes, please list: (For extra space add another sheet of paper). No ☐ Yes ☐

3. Has your child been in hospital for any health problems including previous surgery? If yes, what and when were they? (Please list) No ☐ Yes ☐

Health problem/surgery	Hospital	Year

4. Does your child have any diagnosed disabilities or special needs? If yes, please list. No ☐ Yes ☐

5. Has your child seen any other specialist doctor/s? If yes, please list: No ☐ Yes ☐

Reason for seeing Dr	Dr's name	Dr's Phone Number	Last visit (date)

6. Does your child use any regular medications? (e.g. pills, injections, puffers, implants, herbal, bush medicine and non-prescribed medications). If yes, please list below. Attach list if more space req. No ☐ Yes ☐

Medication/dose:	When taken:	How often:

Appendix 2 – Patient Health Questionnaire – Paediatric – 1/2

7. Does your child have any allergies (especially to medicines, sticking plaster, iodine, food, latex). No ☐ Yes ☐

If yes, what are they and what reaction do they have? _____

8. Has your child had previous anaesthetics? If yes, what for and when? _____ No ☐ Yes ☐

9. Are you aware of any problems your child has with general anaesthetics? No ☐ Yes ☐

If yes, please describe: _____

10. In your child's family, are you aware of any problems with general anaesthetics? No ☐ Yes ☐

If yes, please describe: _____

11. Do you or your child have any questions about the anaesthetic? If yes, what are they? No ☐ Yes ☐

12. Does your child have at present or have they ever had:

		If yes:
A recognised medical condition or syndrome?	No ☐ Yes ☐	Condition/doctor: _____
Heart problems	No ☐ Yes ☐	Condition/doctor: _____
Asthma	No ☐ Yes ☐	How often: _____
Should your child be using a puffer (e.g. Ventolin)	No ☐ Yes ☐	How often: _____
Other lung or breathing problems (e.g. snoring, stops breathing during sleep – sleep apnoea)	No ☐ Yes ☐	What type: _____
Reflux of acid or food – heartburn / hiatus hernia	No ☐ Yes ☐	How often: _____
Diabetes	No ☐ Yes ☐	What type & treatment: _____
Previous exposure to cortisone, similar steroids	No ☐ Yes ☐	When & what type: _____
Epilepsy or fits	No ☐ Yes ☐	How often: _____
Bleeding or bruising problems	No ☐ Yes ☐	What type: _____
Bleeding or bruising problems in a family member	No ☐ Yes ☐	What type: _____
Anaemia or previous blood transfusion	No ☐ Yes ☐	When: _____
Kidney condition	No ☐ Yes ☐	What type: _____
Hepatitis or liver condition	No ☐ Yes ☐	What type: _____
Is your child's immunisation up to date?	No ☐ Yes ☐	What type: _____
Has your child had exposure to in the last three weeks, or do they currently have measles, chicken pox, rheumatic fever, or any other infectious disease?	No ☐ Yes ☐	What type: _____
Is there a condition that runs in the family e.g. thalassemia, muscle dystrophy?	No ☐ Yes ☐	What condition: _____

Form completed by: Parent ☐ Carer/relative/guardian ☐ Other ☐ Specify:

Signature of person completing form: Date:

Appendix 2 – Patient Health Questionnaire – Paediatric – 2/2

ACI/D15/7948
Published: Dec 2016 Review date: 2023 Published by ACI © State of New South Wales (Agency for Clinical Innovation)