



The Department of Anesthesiology at the Texas Tech University Health Sciences Center and the Outpatient Surgery Center of University Medical Center have developed this questionnaire in order to make the process of preparing you for your outpatient surgery more efficient.

Both a nurse and the anesthesiology team will review this information with you. They will do their best to answer whatever questions that you may have.

We thank you very much for your time.

Dear Patient

Please keep this page

SOME THINGS TO REMEMBER:

Adults:

Adults patients must not eat or drink anything after midnight on the night before surgery. Your doctor will instruct you on the medications you may take. If your surgeon or anesthesiologist requests that you take a medication on the morning of surgery, please take it with a sip of water only. If you have trouble swallowing pills with water, please call us at UMC's Outpatient Surgery Center, and ask for advice, Monday through Friday, 9 a.m. to 5 p.m. at 806-775-8525 .

You must arrange for an adult to take you home from the hospital. You cannot drive yourself home. This person should be able to act on your behalf if necessary.

Children Only:

Children may not have milk or solid food after midnight on the night before surgery. They may have clear liquids up until four hours before they are supposed to arrive at the hospital. Clear liquids include water, apple juice, Pedialyte or sugar water.

Babies should be given clear liquids up until four hours before they are supposed to arrive at the hospital. Infants should be awakened if necessary to give them some clear liquids.

Surgery Schedule:

Surgery schedules are difficult to estimate. Unexpected delays occur and waits may be unavoidable. Please plan to be in the Outpatient Surgery Center all day.

Illness:

Fever, colds or other conditions may cause problems during your surgery. If you become ill prior to the day of your surgery, please call us at Outpatient Surgery Center, so that we can make sure that you are ready for your surgery. You may call 806-775-8525, Monday through Friday, 9 a.m. to 5 p.m. After hours please notify your surgeon.

OUR GOAL IS TO PROVIDE YOU WITH VERY GOOD CARE

Patient Name: _____ Date _____

Heart or Blood Problems:

- Has your child ever turned blue? **Yes No**
- Does your child have a heart problem? **Yes No**
- Has your child ever had a study done on his(her) heart? **Yes No**
 - If yes, when did you have it done?
 - If yes, where did you have it done? _____
- Does your child bleed easily? **Yes No**
- Is your child anemic? **Yes No**

Does your child have any of the following problems?

- Neurological disease? **Yes No**
- Muscle disease? **Yes No**
- Seizures? **Yes No**
- Kidney disease? **Yes No**
- Liver disease? **Yes No**
- Hepatitis? **Yes No**
- Loose teeth **Yes No**

Past Surgeries:

- What operations has your child had in the past? Please list.

<u>Operation</u>	<u>Year</u>
➤ _____	_____
➤ _____	_____
➤ _____	_____
➤ _____	_____

- Has your child ever had a problem with anesthesia? **Yes No**
If yes, please tell us about it.

- As far as you know, has anyone in your child's family , whether on the father's or the mother's side of the family, ever had a problem with anesthesia? **Yes No**
If yes, please tell us about it.

Allergies:

- Does your child have any allergies to drugs? **Yes No**
- Please list the drug and describe what happened when you took the drug.

<u>Drug</u>	<u>Reaction</u>
➤ _____	_____
➤ _____	_____

Patient Name: _____ Date _____

Is your child allergic to any foods? **Yes No**

Please list the food and describe what happened when you ate that/those food items:

<u>Food</u>	<u>Reaction</u>
➤ _____	_____
➤ _____	_____

Is your child allergic to anything else such as tape or iodine? **Yes No**

Other Problems:

- Are there any other medical problems that your child has that we have not asked about? Please tell us about it? **Yes No**

Medicines:

- Please list your medicines, how much you take and how often you take them.

<u>Medication:</u>	<u>Dosage:</u>	<u>Time Taken:</u>
➤ _____	_____	_____
➤ _____	_____	_____
➤ _____	_____	_____
➤ _____	_____	_____
➤ _____	_____	_____

- Please write down the name and address of your pharmacy: _____

- Please list whatever herbal supplements, vitamins, or over-the-counter drugs that your child takes on a regular basis.

Physicians:

- Please list the names and addresses of your child’s primary care doctor(s), as well as your child’s heart doctor, if your child has one.

Physician’s name:	Address:
_____	_____
_____	_____

Parent or Guardian Signature: _____

Thank you for your time. We believe the information you have provided on this form will help us to serve you better and make your experience in the operating room safer.