Appendix 4: Medical history questionnaire

Child's name	Age	Sex	Weight	Height
Parent/caregiver's name				

Does the child suffer from, or is there a history of, the following? Tick either "yes" or "no" and, if any answer is "yes", provide a detailed explanation.

	YES	NO
1. Cardiovascular disease		
High blood pressure		
Heart valve lesion, rheumatic fever, or congenital heart disease		
Dysrhythmia, or fainting spells		
Shortness of breath when feeding, lying down, or walking on a level surface		
Episodes of blueness of lips/tongue/fingers/toes		
If any answer is "yes", please provide a detailed explanation:		
2. Respiratory disease		
Do either of the parents smoke?		
History of snoring		
Breathing difficulties		
Lung disease (e.g. asthma, tuberculosis)		
If any answer is "yes", please provide a detailed explanation:		
3. Central nervous system disorders		
Epilepsy, or fits (convulsions)		
Behavioural problems, attention deficit disorder, or developmental delay		
If any answer is "yes", please provide a detailed explanation:		
4. Blood disorders		
Anaemia, sickle cell disorder, or thalassaemia		
Abnormal bleeding associated with previous dental extractions, surgery or trauma, or does the child bruise easily?		
If any answer is "yes", please provide a detailed explanation:		
5. Endocrine disorders		
Diabetes mellitus		
If the answer is "yes", please give details of medication and degree of control of blood sugar:		

6. Liver disease		
Hepatitis, or jaundice		
Other liver disease		
If any answer is "yes", please provide a detailed explanation:		
7. Kidney disease		
Renal disease or disorders, or renal failure		
If the answer is "yes", please provide a detailed explanation:		
8. Musculoskeletal disorders		
Muscle disorders (e.g. myopathy, dystrophy or progressive weakness)		
Orthopaedic problems		
If the answer is "yes", please provide a detailed explanation:		
9. Infectious diseases		
If the answer is "yes", please provide a detailed explanation:		
10. Stomach problems		
Reflux, or regurgitation		
If the answer is "yes", please provide a detailed explanation:		
11. Previous admission to hospital		
If the answer is "yes", please provide a detailed explanation:		
12. Previous operations		
If the answer is "yes", please provide a detailed explanation:		
13. Previous adverse or unpleasant reaction to anaesthesia/sedation		
If the answer is "yes", please provide a detailed explanation:		
14. Previous problems or complications with sedation (e.g. failed sedation)		
If the answer is "yes", please provide a detailed explanation:		
15. History of allergy in general, or allergic reactions to medications		
If the answer is "yes", please provide a detailed explanation:		
16. History of taking medication or drugs, including herbal remedies and recreational drugs		
If the answer is "yes", please provide a detailed explanation:		
17. History of hereditary disease in the child's family (e.g. porphyria, or malignant hyperthermia)		
If the answer is "yes", please provide a detailed explanation:		

21. Is there anything you would like to discuss, but would prefer not to write down?		
If the answer is "yes", please contact your sedation practitioner and discuss this with him/her before the date of your procedure.		

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Signature (Parent/Guardian/Responsible Person) Date

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Signature (Patient, if possible) Date