AUSTIN RADIOLOGICAL ASSOCIATION
Pediatric Pre-Sedation Questionnaire

MRN: Folder #: 17   Scheduled Date:   Document Name: Date of Birth: ____________

Patient Name: __________________________________________

Parent/Guardian Name: ____________________________________

ALL AGES:

1. Does your child have any language, hearing or sight impairments? If yes, please explain. Y N

2. Does your child snore or have difficulty breathing when lying on his/her back? Y N

3. Does your child have history of illness such as heart murmurs, V-P shunts, seizures, asthma, or Arnold Chiari? If yes, please explain. Y N

4. Is your child taking any prescriptions or over-the-counter medications? If yes, what and why? Y N

5. Does your child have any drug allergies? If yes, what drugs? Y N

6. Does your child have a cold, swollen tonsils, cough or fever at this time? Y N

7. Does your child have any history of mental disabilities or hyperactivity? If yes, please explain. Y N

8. Is there anything else regarding the health of your child that may affect him/her while undergoing this procedure? If yes, please explain. Y N

9. What is the reason for this test? __________________________________________

TEN MONTHS OR YOUNGER:

10. Has your child ever needed supplemental oxygen? If yes, when, how long, and under what circumstances? Y N

11. Did your child have apnea (temporary stopping in breathing) or bradycardia (slow heart beat)? Y N

12. Has your child ever been placed on monitors? If yes, please explain, including the duration of monitoring. Y N

13. Was your child born prematurely or were there any complications with the childbirth? If yes, please explain. Y N

14. Does your child have a history of reflux, GI (abdominal) problems or feeding tube/button? If yes, please explain. Y N

I acknowledge that the above answers to this questionnaire are accurate to the best of my knowledge.

Parent/Guardian Signature __________________________ Date ____________

ARA Nurse/Paramedic __________________________ Date ____________