AUSTIN RADIOLOGICAL ASSOCIATION
Pediatric Pre-Sedation Questionnaire

Patient Name: _____ **Date of Birth:** _____

Parent/Guardian Name: _____

ALL AGES: **YES or NO**

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

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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

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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

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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