AUSTIN RADIOLOGICAL ASSOCIATION
Pediatric Pre-Sedation Questionnaire

MRN: Folder #: 17 Scheduled Date: Document Name:

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

Parent/Guardian Name: _____

		(please circle) YES or NO	
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