



Pre-Op Form

Please complete entire form and fax to ARCh two days prior to scheduled surgery date. Thank you for allowing ARCh to provide your child with the best possible care. **Questions:** 214-217-2724 **Fax:** 972-386-2158

*Remember not to allow your child to have any clear liquids 3 hours prior to surgery.

Patient's Name _____ Patient's DOB _____

Procedure _____	Surgeon _____
Will you need assistance with written materials <input type="checkbox"/> Y <input type="checkbox"/> N	Preferred Language _____

Breast fed <input type="checkbox"/> Y <input type="checkbox"/> N	Bottle fed <input type="checkbox"/> Y <input type="checkbox"/> N	Drinks from a cup <input type="checkbox"/> Y <input type="checkbox"/> N
Has your child been exposed to any of the following:		
Tuberculosis <input type="checkbox"/> Y <input type="checkbox"/> N	Chicken Pox <input type="checkbox"/> Y <input type="checkbox"/> N	Does anyone smoke around your child? <input type="checkbox"/> Y <input type="checkbox"/> N

Allergies to medications, foods, etc.	Current Medications/Dosages/Frequency (include over the counter, herbal and respiratory treatments)
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Medical History:

Developmental Delay <input type="checkbox"/> Y <input type="checkbox"/> N	Recent Cold/Flu <input type="checkbox"/> Y <input type="checkbox"/> N	Loose/damaged teeth <input type="checkbox"/> Y <input type="checkbox"/> N
Genetic Disorder <input type="checkbox"/> Y <input type="checkbox"/> N	ADD/ADHD <input type="checkbox"/> Y <input type="checkbox"/> N	Cardiac/Heart problems <input type="checkbox"/> Y <input type="checkbox"/> N
Seizures <input type="checkbox"/> Y <input type="checkbox"/> N	Seasonal allergies <input type="checkbox"/> Y <input type="checkbox"/> N	Heart murmur <input type="checkbox"/> Y <input type="checkbox"/> N
History of snoring <input type="checkbox"/> Y <input type="checkbox"/> N	Acid reflux <input type="checkbox"/> Y <input type="checkbox"/> N	Healthy newborn <input type="checkbox"/> Y <input type="checkbox"/> N
Asthma/Reactive Airway Disease <input type="checkbox"/> Y <input type="checkbox"/> N		Liver/Kidney problems <input type="checkbox"/> Y <input type="checkbox"/> N
If yes, give date of last treatment ____/____/____		Diabetes/Endocrine problems <input type="checkbox"/> Y <input type="checkbox"/> N

If you answered yes to any of the previous questions please explain: _____

Has your child ever been hospitalized for any reason? Explain: _____

Other concerns _____ Last Menstrual Period ____/____/____

Surgical History: Previous surgeries/date _____ _____	Problems with anesthesia: Nausea/Vomiting <input type="checkbox"/> Y <input type="checkbox"/> N Delayed awakening <input type="checkbox"/> Y <input type="checkbox"/> N Family history of problems <input type="checkbox"/> Y <input type="checkbox"/> N Excessive agitation <input type="checkbox"/> Y <input type="checkbox"/> N (after awakening from anesthesia)
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I have fully reviewed this form and have answered to the best of my knowledge. I understand that each answer may affect my child's care.

Signature _____ Date ____/____/____ Relationship _____

Logo/Surgeon Name

Patient Identification