NEW PATIENT MEDICAL INFORMATION – CHILD > 2 YEAR

Purpose: At Pediatric Cardiology Care, we strive to deliver a complete and thorough evaluation for your child. To help us achieve this, please complete the following to the best of your ability. Your answers are confidential. If you have any questions or concerns regarding the questions or information below, please discuss with your healthcare provider.

Date of Appointment: ____________________

Patient's Full Name: _____________________________________ Nickname (if any): _________________________

Patient's DOB: ____/____ /_______ Age: ______ PCP or Referring Physician: _____________________________

What is your main reason for your visit today? ____

PATIENT'S CURRENT HEALTH (

My child's overall health is:	Excellent	Good	Fair	Poor
My child's activity level is:	High	Normal	Below Avg.	Minimal
My child's overall endurance with physical activity is:	High	Normal	Low	

	Yes	No
Has your child complained repeatedly or consistently about chest pain/discomfort?		
Does your child appear short of breath or winded with physical activity?		
Has your child even been diagnosed with asthma? If so, when?		
Has your child complained of palpitations (heart racing, skipped beats, irregular rhythm)?		
Has your child complained of dizziness or lightheadedness? Has he/she fainted?		
Does your child drink caffeinated drinks (soda, tea, energy drinks, etc.) more than 2 days per week?		

REVIEW OF SYSTEMS

	Yes	No	Comments/Details
Problem(s) with overall health			
Problem(s) with weight gain/development			
Problem(s) with eyes/ears/nose/throat			
Problem(s) with breathing or lungs			
Problem(s) with nausea/vomiting/feeding/diarrhea			
Problem(s) with genitals/urinary system			
Problem(s) with joints/muscles/bones			
Problem(s) with skin			
Problem(s) with bleeding/immune system/fever			
Problem(s) with allergies/hives			
Problems with weakness/seizures			
Problems with behavior/ADHD/mental illness			

MEDICATIONS/ALLERGIES *(please circle)*

Does your child have allergies to any medications? Yes No

Is your child allergic to latex? Yes No

Is your child currently taking any regular medications? Yes No

If yes, please list on next page:

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Medication	Strength/Concentration and Dosage (if known)

○ My child takes regular medications, but I cannot recall the name(s) or dosage(s).

PAST MEDICAL HISTORY

	Yes	No	Comments
Does your child have chronic medical problems?			
Was your child born early/prematurely (i.e. before 37 weeks gestation)?			
Has your child ever needed surgery?			
Other hospitalizations?			
Blood transfusion?			
Allergic reaction to medication?			

FAMILY HISTORY

	Mother	Father	Brother/ Sister	Grand-parents	Other family (pls specify)
Heart defect at birth requiring surgery or medication					
Heart rhythm abnormality (arrhythmia)					
Heart valve problem					
Heart muscle disease (cardiomyopathy)					
Sudden or unexplained death <50 years old					
High cholesterol/Coronary artery disease/Stroke					
High blood pressure (hypertension)					
Thyroid abnormalities					

○ I do not know my child's family history (patient is adopted or information not available).

FAMILY GENERAL HEALTH/SOCIAL HISTORY *(please circle)*

The overall health of our family is:	Excellent	Good	Fair	Poor
Do you have any safety concerns at home or school?	Yes	No		
Do you have any concerns regarding alcohol/drug use?	Yes	No	N/A	
I/We regularly have my child wear a seat belt when riding in a car.	Yes	No		
My child's immunizations are up to date.	Yes	No		

The above information is true/correct to my knowledge. ______________________________ (Parent/Guardian signature)

I have reviewed this questionnaire. ______________________________ (Physician signature)