Pediatric Cardiology Care

NEW PATIENT MEDICAL INFORMATION – INFANT/TODDLER < 2 YEARS

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

Current method of feeding (*circle one*) Breastfeeding Bottle (_____oz per feed) Both
How often does your child feed? Every _____ hours
If bottle feeding, how long does your child take to finish a bottle? _____ minutes

	Yes	No
Does your child have unusually fast breathing or sweating when feeding?		
Have you or your pediatrician had concerns about your child's weight gain?		
Have you or your pediatrician had concerns about your child's breathing?		
Has your child ever had concerning color changes or unexplained/unusual fussiness?		
Do you feel that your child has good energy/activity level?		
Has your child been meeting his/her developmental milestones?		

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			

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)

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

PAST MEDICAL HISTORY

How much did your child weigh at birth? _____ lb. _____ oz.

	Yes	No	Comments
Were there any concerns or complications during the pregnancy with this child?			
Was your child born early/prematurely (i.e. before 37 weeks gestation)?			
Did your child go home from the hospital with you after birth?			If not, how long did he/she stay in the nursery/ NICU? _____
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					

O 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? Yes No

I/We regularly use a car seat for my child. 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)