

Pediatric Cardiology Patient Information Form

Name: _____

Date: _____

Primary Care Physician: _____

Why were you referred to Pediatric Cardiology? What are your major concerns?

Does patient smoke: Yes No N/A

Has the patient had any of the following symptoms or problems:

Check

Circle

- Breathing Problems Wheezing Shortness of breath With exercise
- Color Change Blue Pale
- Feeding Problems Poor weight gain Sweating Prolonged feeding time
- Chest Pain Sharp Dull Squeezing Duration _____
- Fast Heart Rates Racing Sudden change in rate? Duration _____
- Difficulties with Exercise Easy Fatigue Shortness of Breath Racing Heart
- Fainting Lightheadedness Dizziness Blacking out Vision loss

List current medications and dosage:

Allergies:

Are immunizations up-to-date? __Yes __No

Any hospitalizations or surgeries? List age and reason

Family History:

Is patient adopted?

If yes can this be discussed in the presence of the patient?

Born with heart defects _____

Coronary heart disease (under age 55) _____

Rhythm abnormalities _____

Fainting _____

Seizures _____

High blood pressure (under age 45) _____

Other heart conditions _____

Asthma _____

Diabetes _____

Kidney disorders _____

Blood disorders _____

Problem with general anesthesia _____

Other medical conditions that run in the family _____

Drug or Alcohol abuse _____

Social History:

Who lives at home with the patient?

Mother _____ Sister(s): Ages: _____

Father _____ Brother (s): Ages: _____

Others: Relationship _____

Any unusual stress or problems at home?

Any other information that you feel is important to provide to us?