

New Patient Medical Information Questionnaire

This questionnaire is designed to help the medical staff of **Pediatric Heart Specialists** learn about you/your child's medical, social and developmental history. Health history is extremely important to us. **Please take the time to completely and fully answer the following questions** so we can be of better help to you/your child. Your answers are considered confidential. If any questions arise in filling out any portion of this questionnaire, please leave those spaces blank until you speak with the doctor.

Appt. Date _____ Patient Name _____ Nickname _____
First Middle Initial Last

DOB _____ Age _____ Gender **M** **F** Primary Care Physician _____
Circle one

Why are you here today? _____

Current Health Please check the best answer to each question below pertaining to the patient.

1. (For baby) On average, he/she will take _____ ounces at one feeding.
2. (For baby) It usually takes about _____ minutes for him/her to finish a bottle (or breast).
3. (For baby) He/she seems to easily get short winded or out of breath when bottle- or breast-feeding. Yes No
4. Overall, my/my child's current health is very good good fair poor.
5. Describe any cardiac-related symptoms or problems you feel you/your child might be having:

6. I am/My child is very active normally active for age not very active.
7. I have/My child has above normal physical endurance normal endurance poor endurance.
8. I seem/My child seems to get out of breath very easily with just usual activities. Yes No
9. I do/My child does vigorous physical activity/work/sports regularly. Yes No
10. I/My child can keep up with others when doing vigorous physical activity. Yes No
11. Overall, I am/my child is often sick not often sick.
12. I have/My child has a persistent or recurring problem with worrisome chest pain. Yes No
13. I have/My child has unusual skipping or irregularity of the heartbeat. Yes No
14. I have/My child has elevated blood pressure. Yes No
15. Normally my/my child's breathing pattern is comfortable (normal) often short of breath.
16. I have/My child has asthma. Yes No
17. My/My child's asthma is mild moderate severe not applicable. Yes No
18. I have/My child has a recurring problem with unusual racing of the heart. Yes No
19. I have/My child has a history of fainting spells (passing out). Yes No
 If yes, explain _____
20. I have/My child has a history of seizures or convulsions. Yes No
21. Overall, I consider my/my child's current weight to be normal underweight overweight.
22. My/My child's appetite is normal fair poor.
23. My/My child's weekly intake of caffeine is none minimal moderate heavy.
24. I have/My child has a proper daily habit of brushing the teeth. Yes No
25. I have/My child has been to the dentist in the past year. Yes No
26. I require/My child requires a dose of antibiotic one hour prior to any dental work, cleaning or surgery. Yes No

Recent symptoms or health issues of patient	No	Yes	If yes, explain briefly
1. Problem with general health, growth, development			
2. Unusual weight change			
3. Problem with eyes/vision			
4. Problem in area of head, ears, nose, sinuses, throat			
5. Problem with lungs/breathing			
6. Problem with stomach, digestion, intestinal system			
7. Problem in genital or urinary system			
8. Problem in muscles, joints, back, neck, bones			
9. Skin problem			
10. Chronic headaches, nerve problems			
11. Behavioral issues			
12. Problem with endocrine glands, lymph glands			
13. Unusual bleeding problem, anemia			
14. Immune system/HIV			
15. Allergies, hives, hayfever			
16. Unexplained fever			
17. Speech or hearing problem			

Check all allergies and describe any reactions below the category.
 None Seasonal Medications Food Dye Latex Other _____

Have you ever.....	No	Yes	Explain briefly
Been hospitalized?			
Had a serious illness (hepatitis, meningitis, etc.)?			
Had surgery?			
Had any serious injury?			
Had any specific drug allergies?			
Had a blood transfusion?			
Had any medication intolerance (vomit, diarrhea)?			

Family History Please check all that apply to **patient's** family members.

	Father	Mother	Brother/Sister	Paternal Grandparents	Maternal Grandparents	Other Family
Birth defect of the heart						
Heart attack or coronary artery disease						
Heart rhythm problem (arrhythmia)						
Heart disease						
Sudden unexplained death of a young person						
High cholesterol or triglycerides						
Mitral valve prolapse						
High blood pressure or stroke						
Serious problem with anesthesia						
Asthma, hayfever, serious allergies						
Bleeding disorder						
Diabetes, epilepsy, cancer, thyroid disease						

Please fill in name age and current health status of **patient's** primary family members. *Parents currently together Yes No

Father		Mother		Patient		Brother/Sister	
Name		Name		Name		Name	
Age		Age		Age		Age	
Health		Health		Health		Health	

Brother/Sister		Brother/Sister		Brother/Sister		Brother/Sister	
Name		Name		Name		Name	
Age		Age		Age		Age	
Health		Health		Health		Health	

Family General Health and Safety

	Yes	No	N/A
Generally use lap and shoulder seat belts			
Use helmet for bicycle or all-terrain vehicle			
Avoid tobacco, alcohol, drug use			
Limit fat and cholesterol in diet			
Participate in vigorous physical activity at least three times a week			
Have dental appointment once or twice a year			
Currently up to date with immunizations			

Birth History of Patient

- My mother was healthy during her pregnancy with me. Yes No
- She had a full-term (9 months) pregnancy. Yes No
- I was born at _____, _____, _____
Hospital City State
- I weighed _____ lbs., _____ oz. at birth.
- I had medical problems during the first few days of my life. Yes No
 If yes, please give details _____.

Social History Please answer questions as pertaining to **patient**.

- I handle my current educational program and/or work very well okay have problems not applicable.
- I have behavioral or psychological problems. Yes No
- I have problems with cigarette smoking Yes No Marijuana smoking Yes No
 Chewing tobacco Yes No Alcohol Yes No Drugs Yes No

Medications Please list all medications the **patient** is currently taking (or write **none**).

Medication	Strength of tablet or liquid	Dosage

Medication	Strength of tablet or liquid	Dosage

The above information is true and correct. _____

Patient/Guarantor Signature

I have reviewed this questionnaire. _____

Physician Signature