

East Tennessee Pediatric Cardiology, PC  
2001 Highland Ave, Suite B  
Knoxville, TN 37916  
Ph: 865-971-6897  
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Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Referring Physician: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

When did this problem first begin? \_\_\_\_\_

Have you had any testing for this problem? Yes/No

If yes, what type of testing? \_\_\_\_\_ When? \_\_\_\_\_ Where? \_\_\_\_\_

What were the results of the tests? \_\_\_\_\_

Do you have (or have ever had) one or more of the following (circle); and if so, when/describe:

- |                                  |              |
|----------------------------------|--------------|
| 1. Heart murmur:                 | Yes/No _____ |
| 2. Chest pain:                   | Yes/No _____ |
| 3. Fainting/passing out:         | Yes/No _____ |
| 4. Fast or irregular heart beat: | Yes/No _____ |
| 5. Difficulty breathing:         | Yes/No _____ |
| 6. Tiring easily:                | Yes/No _____ |
| 7. Swelling:                     | Yes/No _____ |
| 8. High/low blood pressure:      | Yes/No _____ |
| 9. Seizures:                     | Yes/No _____ |
| 10. Excessive weight loss/gain:  | Yes/No _____ |

Do you have (or have ever had) any significant illnesses or hospitalizations?

Yes/No

If yes, what and when? \_\_\_\_\_

Have you ever had surgery? Yes/No

If yes, what type and when? \_\_\_\_\_

**Family History:**

**Does anyone in your family (parents/siblings/grandparents/aunts/uncles/cousins) have (or ever had) one or more of the following (circle); and if so, who:**

- 1. Congenital heart disease Yes/No \_\_\_\_\_
- 2. Early heart disease/ heart attack Yes/No \_\_\_\_\_
- 3. High blood pressure Yes/No \_\_\_\_\_
- 4. High cholesterol Yes/No \_\_\_\_\_
- 5. Stroke Yes/No \_\_\_\_\_
- 6. Cardiomyopathy Yes/No \_\_\_\_\_
- 7. Sudden unexplained death Yes/No \_\_\_\_\_
- 8. SIDs Yes/No \_\_\_\_\_
- 9. Fast/ irregular heart beat Yes/No \_\_\_\_\_
- 10. Fainting/ passing out /Seizues Yes/No \_\_\_\_\_
- 11. Diabetes/ Thyroid disease Yes/No \_\_\_\_\_
- 12. Asthma Yes/No \_\_\_\_\_
- 13. Cancer Yes/No \_\_\_\_\_
- 14. Rheumatic Fever Yes/No \_\_\_\_\_
- 15. Kidney Disease Yes/No \_\_\_\_\_
- 16. Muscular Dystrophy Yes/No \_\_\_\_\_
- 17. Hearing loss Yes/No \_\_\_\_\_
- 18. Inflammatory Bowel Disease Yes/No \_\_\_\_\_
- 19. Psychiatric illness Yes/No \_\_\_\_\_
- 20. Down's Syndrome Yes/No \_\_\_\_\_
- 21. Other chromosome problem/ Syndrome Yes/No \_\_\_\_\_

**Social History:**

**(circle) married/divorced/single**

**Do you have any children? Yes/No      Medical problems?**

name/age \_\_\_\_\_ (none)

name/age \_\_\_\_\_ (none)

name/age \_\_\_\_\_ (none)

name/age \_\_\_\_\_ (none)

**Who lives in your home? \_\_\_\_\_**

**Do you use tobacco? Yes/No      If yes, how much? \_\_\_\_\_**

**Drugs? Yes/No      If yes, what/how much? \_\_\_\_\_**

**Alcohol? Yes/No      If yes, how much? \_\_\_\_\_**

**Current Medications:      (or circle) No Current Medications**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_
- 6. \_\_\_\_\_

**Allergies to any medications:      (or circle) No Medication Allergies**

\_\_\_\_\_

**Do you have (or have ever had) one or more of the following (circle); and if so, when/describe:**

<b>1. Constitutional (night sweats/ chills/ unexplained fever/ other)</b>	<b>negative</b>
<b>2. Eyes (loss of vision/ trouble seeing/ double vision/ other)</b>	<b>negative</b>
<b>3. Ears (hearing loss/ ear pain/ vertigo/ other)</b>	<b>negative</b>
<b>4. Nose (nosebleeds/ sinus trouble/ frequent colds/ other)</b>	<b>negative</b>
<b>5. Mouth/throat (Strep throat/ bleeding gums/ bad teeth/ other)</b>	<b>negative</b>
<b>6. Chest/ lungs (wheezing/ coughing/ TB exposure/ Cystic Fibrosis/other)</b>	<b>negative</b>
<b>7. Gastrointestinal (vomiting/ diarrhea/ liver disease/ bloody stool/ other)</b>	<b>negative</b>
<b>8. Genitourinary (infections/ kidney reflux/ blood in urine/ other)</b>	<b>negative</b>
<b>9. Hematologic (anemia/ easy bruising/ blood disease/ other)</b>	<b>negative</b>
<b>10. Endocrine (thyroid disease/ diabetes/ other)</b>	<b>negative</b>
<b>11. Musculoskeletal (arthritis/ joint redness/ bony deformity/ other)</b>	<b>negative</b>
<b>12. Neurologic (frequent headaches/ dizziness/ head injury/ weakness/ other)</b>	<b>negative</b>
<b>13. Psychiatric (depression/ bipolar disorder/ ADHD/ ADD/ trouble sleeping/ other)</b>	<b>negative</b>

**Thank you for taking the time to answer these questions that will help us better care for you!**