

East Tennessee Pediatric Cardiology, PC
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Knoxville, TN 37916
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Patient's Name: _____ Date of birth: _____

Primary Care Physician: _____ Referring Physician: _____

Today's Date: _____

Why are we seeing your child today? _____

When did this problem first begin? _____

Has your child had any testing for this problem? Yes/No

If yes, what type of testing? _____ When? _____ Where? _____

What were the results of the tests? _____

Does your child have (or has 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. Turning blue: | Yes/No _____ |
| 5. Fast or irregular heart beat: | Yes/No _____ |
| 6. Problems with feeding: | Yes/No _____ |
| 7. Difficulty breathing: | Yes/No _____ |
| 8. Tiring easily: | Yes/No _____ |
| 9. Excessive sweating: | Yes/No _____ |
| 10. Excessive irritability: | Yes/No _____ |
| 11. Swelling: | Yes/No _____ |
| 12. High/low blood pressure: | Yes/No _____ |
| 13. Seizures: | Yes/No _____ |
| 14. Excessive weight loss/gain: | Yes/No _____ |
| 15. Developmental delay: | Yes/No _____ |

Does your child have (or ever had) any significant illnesses or hospitalizations?

Yes/No

If yes, what and when? _____

Has your child ever had surgery? Yes/No

If yes, what type and when? _____

Birth History:

Birth weight: _____ **Gestational age:** _____ **Place of birth:** _____

Complications during pregnancy/delivery: _____

Complications after birth: _____

Family History:

Does anyone in the patient's 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:

Who lives in the patient's home? _____

Does anyone smoke? _____

Brothers/Sisters? Name: _____ **age:** _____ **healthy: Yes/No**

or circle Name: _____ **age:** _____ **healthy: Yes/No**

(None) Name: _____ **age:** _____ **healthy: Yes/No**

Name: _____ **age:** _____ **healthy: Yes/No**

What grade in school is your child? _____

Problems at school? _____

Current Medications:

(or circle) No Current Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Allergies to any medications:

(or circle) No Medication Allergies

Does your child have (or has ever had) one or more of the following (circle); and if so, when/describe:

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

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