East Tennessee Pediatric Cardiology, PC
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Patient's Name:______________________________ Date of birth:______________
Primary Care Physician:________________ Referring Physician:______________
Today's Date:______________
Reason for today's visit: ____
Concerns since the last visit: ____
New medical problems/ illnesses/ hospitalizations since the last visit? (circle) yes/ no
problem: __________________ date: __________
problem: __________________ date: __________
problem: __________________ date: __________
problem: __________________ date: __________
problem: __________________ date: __________
Any changes to the family or social history since the last visit? (circle) yes/ no
If yes, please describe: ____

____

Had any of these problems since the last visit?

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 very much for updating your history so that we can better care for you/ your child!