East Tennessee Pediatric Cardiology, PC
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Name:_____ Date of birth:_____
Primary Ob/Gyn:_____ Referring Physician:_____
Today's Date:_____

Your age:_____
How many times have you been pregnant?____
How many living children do you have?_____
How many premature babies?_____
How many miscarriages?_____
How far along are you (in weeks)?_____
Planned method of delivery?_____ Delivery hospital?_____

Reason for today's visit:_____
Was a heart defect seen in your baby's heart? Yes/No
If yes, how far along were you at the time of the ultrasound?_____
Has anyone ever detected a fast or irregular heart beat in your baby? Yes/No
If yes, how far along were you when this was first detected?_____
Did your doctor see any abnormalities on ultrasound (outside of the heart) in your baby? Yes/No
If yes, what abnormalities were seen?_____
Have you had any abnormal testing (e.g quad screen, antibody screen, sugar, urine)? Yes/No
If yes, what?_____
Have you had an amniocentesis? Yes/No
If yes, what were the results?_____

Problems during THIS pregnancy:_____
Problems during PREVIOUS pregnancies/ deliveries:_____
_____
Have you seen any other specialists with regard to THIS pregnancy? Yes/No
If yes, who?_____

Have you had any possible exposures to toxins/ medications/ Xray/ drugs during THIS pregnancy, or before knowing you were pregnant? Yes/No
If yes, what/ when (if known):_____

Do you know of any possible exposures to Toxoplasmosis (cats)/ CMV/ parvovirus during THIS pregnancy? Yes/No
If yes, what/ when:_____

Do you have (or have ever had) any significant medical problems or hospitalizations? Yes/No
If yes, what and when?_____
_____

Have you ever had surgery? Yes/No
If yes, what type and when?_____
_____

Social History:

(circle) married/divorced/single
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:

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 pain/ 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/ liver disease/ bloody stool/ other) negative
_____
8. Genitourinary (infections/ kidney reflux/ blood in urine/ other) negative
_____
9. Hematologic (anemia/ easy bruising/ blood disease/ other) negative
_____
10. Endocrine (thyroid disease/ diabetes/ 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
_____

Family History:

Have you ever had any children with:

1. **Congenital heart disease** **Yes/No**
2. **Fast/ irregular heart beat** **Yes/No**
3. **Cardiomyopathy** **Yes/No**
4. **Sudden unexplained death** **Yes/No**
5. **SIDs** **Yes/No**
6. **Fainting/ passing out/ seizures** **Yes/No**
7. **Rheumatic Fever** **Yes/No**
8. **Muscular Dystrophy** **Yes/No**
9. **Hearing loss** **Yes/No**
10. **Down's Syndrome or other chromosome problem/ Syndrome** **Yes/No**

Does the father of the baby have (or has ever had) any significant medical problems? Yes/No

If yes, what?_____

Has the father of the baby ever had any children with:

1. **Congenital heart disease** **Yes/No**
2. **Fast/ irregular heart beat** **Yes/No**
3. **Cardiomyopathy** **Yes/No**
4. **Sudden unexplained death** **Yes/No**
5. **SIDs** **Yes/No**
6. **Fainting/ passing out/ seizures** **Yes/No**
7. **Rheumatic Fever** **Yes/No**
8. **Muscular Dystrophy** **Yes/No**
9. **Hearing loss** **Yes/No**
10. **Down's Syndrome or other chromosome problem/ Syndrome** **Yes/No**

Does anyone in your or the father of the baby's family (parents/siblings/nieces/nephews) 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**_____

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