East Tennessee Pediatric Cardiology, PC
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Patient History Adult

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:

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**

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