East Tennessee Pediatric Cardiology, PC
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Patient History Child:
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!