

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: _____
Anticipated date of delivery: _____
Name to be given after delivery: _____

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 at the time of the ultrasound? _____
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 of toxins/ medications/ Xrays/ 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 you 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 you ever had) on 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/ blood 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 (or have 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 have 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/ seizures | 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 Bowl 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!