PATIENT HISTORY INTAKE – CARDIOLOGY / CARDIOVASCULAR

(CHILD)

FEEDING HISTORY - (For Babies / Infants Only)

1) If on formula, how many ounces at each feeding?
2) How long does it take the baby to finish one feeding?
3) If breast feeding, how many minutes on each breast?
4) Does the baby suck strongly during a feeding? ◯Yes ◯No
5) Does the baby get tired easily during feeding? ◯Yes ◯No
6) Does the baby sweat or have labored breathing during feeding? ◯Yes ◯No

SOCIAL HISTORY

Does the child live with both parents? ☐Yes ☐No – If No, Lives with:
Mother Age? Father Age? Mother Job? Father Job?
How many siblings does the child have? Age/Sex of Sibling Each?
Do any siblings also have Congenital or other heart disease? [] Yes [] No – If Yes, please detail:
At what grade in school? Any problems at school?
What hobbies/activities does the child enjoy/play? What kind of sport does the child participate in?
Any major stress at home, or school?

GROWTH AND DEVELOPMENT

Does child appear to be growing similar to family pattern? ☐Yes ☐No
Does child have any difficulty keeping up with age group? [] Yes [] No; If yes, please describe below
Is the child up to expectations at school? Any learning or attention problems? [] Yes [] No; If yes, please describe.

PAST MEDICAL AND SURGICAL HISTORY

Prescription & OTC Drugs - Name / Dosage / Frequency		***Any Drug or Food Allergies?*** ☐ Yes ☐ No ☐ Not Known	
		List Drug or Food:	
Operations / Hospitalizations – Reason	***Date***	***Operations / Hospitalizations – Reason***	***Date***

PATIENT'S PAST MEDICAL AND FAMILY HISTORY

PLEASE INDICATE IF YOU OR A RELATIVE - (M) =MOTHER / (F) =FATHER / (S) =SIBLING / (GP) =GRAND PARENT – WAS AFFECTED BY CONDITION

Condition	***You***	***Relatives***	***Condition***	***You***	***Relatives***
Anemia			High Cholesterol or Triglycerides		
Blood Clot or Bleeding Disorder			Kawasaki Disease		
Congenital Heart Disease (Born With)			Mitral Valve Prolapse		
Deaf from Birth (Neuronal)			Rheumatic Fever		
Diabetes - [] Type I [] Type II			Stroke or Mini-strokes (TIA)		
Heart Murmur			Unexplained death in young		
Heart Attack / MI			Thyroid Problems		
High Blood Pressure			Other Cardio-Vascular Disease		

Patient Name: **Date of Service:**

REVIEW OF SYSTEMS HISTORY - DOES YOUR CHILD HAVE ANY OF THE FOLLOWING SIGNS AND/OR SYMPTOMS? **(CHILD)**

PLEASE MARK (X) IF ANY OF THE FOLLOWING APPLY TO YOU **CURRENTLY**, IN THE **PAST** OR **NEVER**

GENERAL HEALTH	CURRENTLY	PAST	NEVER	List Other Signs or Related-Symptoms
Healthy Appetite	☐	☐	☐	
Weight loss or Weight gain	☐	☐	☐	
Fever	☐	☐	☐	
Fever last over 5 days	☐	☐	☐	
Lethargy	☐	☐	☐	
Excessive Fatigue	☐	☐	☐	
EYES				
Vision changes	☐	☐	☐	
EARS, NOSE, THROAT & MOUTH				
Ringing in ears	☐	☐	☐	
Sinus problems or Sore throat	☐	☐	☐	
CARDIO / PERIPHERAL VASCULAR				
Chest Pain or discomfort	☐	☐	☐	
Irregular heart rhythms	☐	☐	☐	
Palpitations	☐	☐	☐	
Color changes in Lips or Tongue	☐	☐	☐	
Swelling around eyes, hands or Feet	☐	☐	☐	
RESPIRATORY				
Coughing or Wheezing	☐	☐	☐	
Shortness of breath	☐	☐	☐	
Difficult breathing on exertion	☐	☐	☐	
Painful breathing	☐	☐	☐	
Rapid breathing	☐	☐	☐	
GASTROINTESTINAL				
Abdominal Pains	☐	☐	☐	
Nausea or Vomiting	☐	☐	☐	
Black or Bloody stool	☐	☐	☐	
Heartburn or Acid reflux	☐	☐	☐	
URINARY				
Blood in urine	☐	☐	☐	
Painful urination	☐	☐	☐	
MUSCULOSKELETAL				
Muscle aches / pains / weakness	☐	☐	☐	
Bone aches / pains / weakness	☐	☐	☐	
Swelling of legs	☐	☐	☐	
Pain in extremities	☐	☐	☐	
SKIN / BREAST				
Masses / Lumps or Rash / Ulcers	☐	☐	☐	
NEUROLOGICAL				
Dizziness	☐	☐	☐	
Fainting	☐	☐	☐	
Forgetfulness or Confusion	☐	☐	☐	
Headaches	☐	☐	☐	
Numbness	☐	☐	☐	
Seizures	☐	☐	☐	
PSYCHIATRIC				
Depression	☐	☐	☐	
Anxiety / Stress	☐	☐	☐	
ENDOCRINE				
Excessive Sweating	☐	☐	☐	
Thyroid problems	☐	☐	☐	
Abnormal thirst	☐	☐	☐	
HEMATOLOGIC / LYMPHATIC				
Bruises, frequent	☐	☐	☐	
Enlarged lymph nodes	☐	☐	☐	
Thyroid problems	☐	☐	☐	

Nurse Note: