PEDIATRIC CARDIOLOGY

MEDICAL HISTORY QUESTIONNARE

Name_____ **Today's Date**_____ **Date of Birth**_____
Nickname_____

Reason for visit _____

ALLERGIES: List any medications or products (e.g. latex) you are **allergic** to AND the **reaction** you have (e.g. rash, throat closing): Check here if no known allergies: ____

Medication/Product	Reaction
_____	_____
_____	_____

MEDICATIONS: List your **current medications**, **dose**, and **when** you take them (e.g. Calcium 500 mg One every morning): Use other side if there are additional meds.

Current Medication	Dose and When you take it
_____	_____
_____	_____
_____	_____

MEDICAL HISTORY: List any **medical problems or hospitalizations** you have had, and the year/ age **at the time**:

Problem	Year/Age	Problem	Year/Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OPERATIONS: List any **operations** or procedures you have had, and the year or your age at the time:

Operation	Year/Age	Operation	Year/Age
_____	_____	_____	_____
_____	_____	_____	_____

Birth History: Birth weight _____ Weeks gestation at birth_____ Any pregnancy/birth complications_____

Who lives in the household with patient? _____

Pediatrician or family doctor _____

Who sent or referred you today? _____

Pharmacy (name, location and phone number) _____

Do you feel that you or your child is at risk for dangerous or threatening situation to your personal safety?
_____yes _____no

Review of systems/Current problems: (if applicable according to age)

	Y	N		Y	N		Y	N		Y	N
Unexplained Weight gain			Appetite change			Fever			Rash		
Unexplained Weight loss			Urine infections			Blueness of lips			Cough		
Seizures			Night sweats			Blue hands/feet			Headache		
Unexplainably fussy (for infants only)			Can't exercise well			Frequent Pneumonia			Shortness of breath		
Chest pain			Wheezing/asthma			Nausea/vomiting			Constipation		
Palpitations			Feeding problems			Autism spectrum			High blood pressure		
Dizziness			Blood in Urine			Diarrhea			High cholesterol		
Fainting			Joint pain/swelling			Swollen feet			Depression		
Hearing problem			Muscle aches			Thyroid problem			Fatigue		
Vision problem			Anemia			Kidney problems			Anxiety		

FAMILY MEDICAL HISTORY: Check the box under the appropriate blood relative *of the patient* for any diseases or disorders in your family. Enter any other blood relative in the right column if needed. Use the extra rows for any other disorders. MGM=maternal grandmother, MGF=maternal grandfather, PGM=paternal grandmother, PGF=paternal grandfather. Maternal is patient's mother's side. Paternal is patient's father's side.

	Mother	Father	MGM	MGF	PGM	PGF	Brother	Sister	Aunt	Uncle	Other
Heart birth defects											
Heart rhythm problems											
Asthma											
Born deaf (hearing loss)											
Bleeding or clotting disorders											
Smoking											
Diabetes (state type I or 2)											
Heart attack < age 55											
Heart attack > age 55											
High blood pressure											
High cholesterol											
Thyroid problem											
Unexplained fainting, seizures or drowning?											
Migraine headaches											
Obesity											
Brugada, Long or Short QT,pacemaker,defibrillator											
Cardiomyopathy (weak or thick heart)											

Further explanation for any of the above: _____

_____

_____

_____