Banner Health®

# NEW PATIENT MEDICAL HISTORY
# PEDIATRIC CARDIOLOGY

**Patient Name:** ______________________________ **Date of Birth:** ______________

**Person filling out form and relationship to patient:** ______________________________

***Please provide as much detail as you are able so that we can give you the safest and best care possible.***

**Preferred Pharmacy (name and location):** ______________________________

**Primary Care Provider:** ______________________________ **Phone #:** ______________

**List other providers your child sees:** ______________________________

**Reason for visit:** ______________________________

______________________________

## IS YOUR CHILD EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS? Circle all that apply.

| | | | |
|---|---|---|---|
| Chest pain | Poor exercise capacity | Syncope | Lightheadedness |
| Blue color (of lips/nail beds) | Fatigue | Fast heart beats | Feeding difficulty |
| Dizziness | Palpitations | Diaphoresis | Poor weight gain |
| Edema (swelling) | Shortness of breath | Pallor | Poor appetite |

## ALLERGIES

❑ **No known allergies** (List any allergies and intolerances to medications, food or the environment).

| Allergy | Reaction |
|---|---|
| | |
| | |
| | |

## MEDICATIONS

❑ **No Medications** List any medications you are taking, with dose and how often.

| Medication name | Preparation (i.e., tablet, suspension) | Dose | How often? | Date medication started |
|---|---|---|---|---|
| | | | | |
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**DO NOT RETAIN AS PART OF THE PERMANENT MEDICAL RECORD**



9999-0134
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## PATIENT MEDICAL HISTORY

List any current or past medical conditions.

___
___
___
___

## SURGERIES AND/OR HOSPITALIZATIONS

Has your child had any surgeries or has been hospitalized? (Please provide dates and reason below)

| Date | Reason | Date | Reason |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

## FAMILY HISTORY

**List any blood relatives (and relationship to patient) that have the following?**

Arrhythmia ____________________
Birth defects ____________________
Clotting disorder ____________________
Coronary artery disease ____________________
Down Syndrome ____________________
Heart defect ____________________
High cholesterol ____________________
Lupus ____________________
Murmurs ____________________
Sudden infant death ____________________
Asthma ____________________
Bleeding problems ____________________
Childhood heart surgery ____________________
Diabetes ____________________
Genetic disorder ____________________
Hearing loss ____________________
Hypertension ____________________
Marfan Syndrome ____________________
Sickle Cell Disease ____________________
Sudden death prior to 50 years of age ____________________

## SOCIAL HISTORY

Patient lives with: ❑ Mother ❑ Father ❑ Siblings (# brothers: _____ # sisters: _____ )
❑ Grandparents ❑ Step-Parents ❑ Foster Parents ❑ Adoptive Parents

Child attends daycare: ❑ Yes ❑ No

Grade in school: ____________ Is child home-schooled? ❑ Yes ❑ No ❑ Child receives special services in school

Pets in Household: ❑ Yes ❑ No If yes, list all pets: ____________________

Smokers in household: ❑ Yes ❑ No If yes, list: ____________________

How often does your child get exercise? ❑ Regularly ❑ Occasionally ❑ Restricted ❑ Physically unable

Does your child participate in organized competitive sports? ❑ Yes ❑ No If yes, list: ____________________

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## FOR PATIENTS 13 YEARS AND OLDER

Tobacco/smoking status: ❑ Never

Current: ❑ Yes ❑ No Amount: ________________ Duration: ____________________

Former: ❑ Yes ❑ No Amount: ________________ Duration: ____________________

Do you use alcohol? ❑ Yes ❑ No Amount: ________________ Frequency: __________________

Do you use recreational drugs? ❑ Yes ❑ No Type: __________________ Frequency: __________________

Do you use Caffeine? ❑ Yes ❑ No Amount: ________________ Frequency: __________________

## MATERNAL AND BIRTH HISTORY

❑ Birth history unknown

Birth Weight: ________ lbs. ________ oz. Length: ____________ Birth Hospital: ________________________________

Type of delivery: ❑ Vaginal ❑ C-Section ❑ Repeat C-Section ❑ Emergent C-Section (Reason) ________________

❑ Full Term ❑ Premature How many weeks was the pregnancy: ______________________________________

Maternal Age at Delivery: ________ Prenatal Care: ❑ Yes ❑ No

Total Number of Pregnancies: _______ Live Births: ______ Abortions: ______ Miscarriages: ______ Stillbirth: ______

Complications during pregnancy? ❑ Yes ❑ No If yes, please explain ______________________________________

Number of days in the hospital: ____________________________

Type of diet: ❑ Breastfed ❑ Bottlefed ❑ Both

## IMMUNIZATIONS

❑ Immunization history unknown ❑ Immunization up-to-date ❑ No immunizations by choice

## MENSTRUAL HISTORY

For female patients

Has your child ever had a menstrual period? ❑ Yes ❑ No If yes, age of onset: ______ Date of last period: ______________

Are they regular (every month)? ❑ Yes ❑ No If no, explain: ____________________________________________

Length of period? ❑ less than 5 days ❑ 5-7 days ❑ more than 7 days

Character of bleeding: ❑ Light ❑ Moderate

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## REVIEW OF SYSTEMS

| CONSTITUTIONAL | | | GASTROINTESTINAL | | | MUSCULOSKELETAL | | |
|---|---|---|---|---|---|---|---|---|
| Activity change | Yes | No | Abdominal distension | Yes | No | Bone deformity | Yes | No |
| Appetite change | Yes | No | Abdominal pain | Yes | No | Muscle aches | Yes | No |
| Fever | Yes | No | Eating problems | Yes | No | Scoliosis | Yes | No |
| Irritability | Yes | No | Nausea | Yes | No | **SKIN** | | |
| Lethargy | Yes | No | Swallowing difficulty | Yes | No | Birthmarks | Yes | No |
| Slow weight gain | Yes | No | Reflux symptoms | Yes | No | Cyanosis | Yes | No |
| Trouble sleeping | Yes | No | Vomiting | Yes | No | Nail changes | Yes | No |
| **EYE** | | | **GENITOURINARY** | | | Rash | Yes | No |
| Eye drainage | Yes | No | Blood in urine | Yes | No | **NEUROLOGICAL** | | |
| Lazy eye | Yes | No | Decreased urination | Yes | No | Dizziness | Yes | No |
| **ENMT** | | | Frequent urination | Yes | No | Developmental Delay | Yes | No |
| Cavities | Yes | No | Painful menses | Yes | No | Headache | Yes | No |
| Gum bleeding | Yes | No | **HEMATOLOGIC** | | | Hyperactivity | Yes | No |
| Hearing loss | Yes | No | Anemia | Yes | No | Seizures | Yes | No |
| Nasal congestion | Yes | No | Easy bleeding | Yes | No | Weakness | Yes | No |
| Nosebleeds | Yes | No | Easy to bruise | Yes | No | **PSYCHIATRIC** | | |
| Sleep apnea | Yes | No | Leukemia | Yes | No | ADD | Yes | No |
| **RESPIRATORY** | | | Other malignancies | Yes | No | ADHD | Yes | No |
| Asthma symptoms | Yes | No | Swollen glands | Yes | No | Depression | Yes | No |
| Cough | Yes | No | **ENDOCRINE** | | | **ALLERGY / IMMUNE** | | |
| Frequent pneumonia | Yes | No | Diabetes | Yes | No | Environmental allergies | Yes | No |
| Shortness of breath | Yes | No | Excessive weight gain | Yes | No | Persistent infections | Yes | No |
| Snoring | Yes | No | Slow growth | Yes | No | | | |
| Wheezing | Yes | No | Thyroid disease | Yes | No | | | |
| | | | Weight loss | Yes | No | | | |
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