PATIENT MEDICAL HISTORY

CHILDREN'S CARDIOLOGY OF THE BAY | 2051 PIONEER COURT, SAN MATEO, CA 94403 | 650-558-8280

PATIENT'S NAME:_____ DOB:_____ TODAY'S DATE:_____

NAME OF PERSON COMPLETING FORM:_____ RELATIONSHIP TO PATIENT:_____

HISTORY OF PRESENT ILLNESS

Reason for consultation?_____

When did problem begin?_____

BIRTH HISTORY

Name of the Hospital where child was born:_____

Birth weight of child _____pounds _____ounces

Was the patient born prematurely? ☐ Yes ☐ No

Were there any complications with the pregnancy? ☐ Yes ☐ No

Were there any complications with the delivery? ☐ Yes ☐ No

Was the patient born by Cesarean section? ☐ Yes ☐ No

If yes to any of the questions above please explain:

_____

GROWTH AND DEVELOPMENT

Normal milestones?..... ☐ Yes ☐ No

Developmental delay?..... ☐ Yes ☐ No

Speech delay?..... ☐ Yes ☐ No

PAST MEDICAL HISTORY

Any Hospital Admissions?..... ☐ Yes ☐ No

Any Surgical procedure?..... ☐ Yes ☐ No

Immunizations up to date?..... ☐ Yes ☐ No

REVIEW OF SYSTEMS

HAS THE PATIENT EVER HAD ANY OF THE FOLLOWING?

If YES to any question below, please explain:

Heart Murmur..... ☐ Yes ☐ No

Fainting/Loss of consciousness..... ☐ Yes ☐ No

Chest Pain..... ☐ Yes ☐ No

Palpitations/Fast heart beats..... ☐ Yes ☐ No

High blood pressure..... ☐ Yes ☐ No

Shortness of breath..... ☐ Yes ☐ No

Weight loss/Failure to thrive..... ☐ Yes ☐ No

Fatigue..... ☐ Yes ☐ No

Pneumonia..... ☐ Yes ☐ No

Asthma..... ☐ Yes ☐ No

Eye problems..... ☐ Yes ☐ No

Ears/nose/throat problems..... ☐ Yes ☐ No

Eating problems or stomach pain..... ☐ Yes ☐ No

Muscle Problems..... ☐ Yes ☐ No

Skin problems/rashes..... ☐ Yes ☐ No

Seizures/Brain problems..... ☐ Yes ☐ No

Hormones problems/Diabetes..... ☐ Yes ☐ No

Blood problems/Anemia..... ☐ Yes ☐ No

Cancer..... ☐ Yes ☐ No

ADHD/ADD/Learning difficulty..... ☐ Yes ☐ No

ALLERGIES..... ☐ Yes ☐ No

Does your child take any medications..... ☐ Yes ☐ No

ALLERGIES TO MEDICATIONS..... ☐ Yes ☐ No

FAMILY HISTORY

Age of Mother:_____ Health Status:_____

Age of Father:_____ Health Status:_____

Age of siblings and Health Status?_____

_____

Any history of congenital heart disease in the family?

_____

HAS ANYONE IN YOUR FAMILY HAD THE FOLLOWING?

Sudden cardiac death before age 50 years..... ☐ Yes ☐ No

High Cholesterol..... ☐ Yes ☐ No

High blood pressure..... ☐ Yes ☐ No

Abnormal heart rhythm/ EKG Abnormality..... ☐ Yes ☐ No

Cardiomyopathy..... ☐ Yes ☐ No

Diabetes..... ☐ Yes ☐ No