



**Pediatric
Heart Center
of Central Oregon**

ADULT CONGENITAL HEART DISEASE CLINIC QUESTIONNAIRE

Date: _____

NAME: _____ DOB: _____ AGE: _____

PRIMARY/REFERRING DOCTOR: _____

DO YOU HAVE ANY CURRENT CONCERNS RELATED TO YOUR HEART?

Do you experience any of the following symptoms?

- Chest Pain
- Shortness of breath
- Ankle swelling
- Dizziness/lightheadedness
- Fainting
- Palpitations: irregular or racing heart beat
- Exercise intolerance
- Fatigue

Do you have any questions or concerns regarding the following (check all that apply)?

- Health insurance
- Work/activity restrictions
- Sexual activity
- Reproductive concerns (pregnancy, genetic issues)
- Long term prognosis
- Depression / anxiety

PAST MEDICAL HISTORY:

Current Medications (and doses):

Allergies to medications: _____

Cardiac diagnosis: _____ don't know

Age at Diagnosis: _____ don't know

Cardiac Surgical Procedures:

Date: _____ Procedure: _____ Doctor: _____ Location: _____

Cardiac Catheterization Procedures:

Date _____ Procedure _____ Doctor _____ Location _____

Other (non-cardiac) surgical procedures:

Date _____ Procedure _____ Doctor _____ Location _____

Other hospitalizations:

Date: _____ Procedure: _____ Doctor: _____ Location: _____

Name(s) of previous cardiologist(s):

Name: _____

Address: _____

Phone: _____

Name: _____

Address: _____

Phone: _____

Do you have any other chronic medical conditions?

Have you been told to take antibiotics prior to dental care? Yes No

Have you been advised to restrict your physical activity? Yes No

Females only: have you had any pregnancies? _____

FAMILY HISTORY:

Have your relatives (including siblings, parents, aunts, uncles, grandparents) had any of the following problems?

- Born with heart defect
- Heart rhythm abnormality
- Early sudden death
- High blood pressure
- Heart attack before age 55
- Stroke before age 55
- Peripheral vascular disease (blockage in leg arteries)
- Diabetes
- Obesity
- High cholesterol

Any other medical problems that run in your family:

SOCIAL HISTORY:

Occupation : _____ Employer: _____

Highest level of education completed: _____

Do you participate in organized sports: (which ones?) _____

Do you exercise regularly (type and frequency)?

Smoking history:

Never:

Yes (type and amount): _____

Used to: (date stopped) _____

Have you used drugs not prescribed by a doctor? (type, frequency and amount)

Do you drink caffeinated beverages? (type and amount)

Do you drink alcohol? (type and amount)

REVIEW OF SYSTEMS:

Has the patient experienced any of the following **IN THE PAST MONTH:**

(please explain any checked boxes below)

General:	None: <input type="checkbox"/>	<input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Weight gain	<input type="checkbox"/> Fever
Skin:	<input type="checkbox"/>	<input type="checkbox"/> Rash	<input type="checkbox"/> Color change		
Eyes:	<input type="checkbox"/>	<input type="checkbox"/> Glasses	<input type="checkbox"/> Other vision problems		
ENT:	<input type="checkbox"/>	<input type="checkbox"/> Ear infections <input type="checkbox"/> Hoarseness	<input type="checkbox"/> Sinus infection <input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Hearing problems <input type="checkbox"/> Cavities or other dental problems	<input type="checkbox"/> Nasal discharge <input type="checkbox"/> Orthodontics
Sleep:	<input type="checkbox"/>	<input type="checkbox"/> Snoring	<input type="checkbox"/> Daytime sleepiness	<input type="checkbox"/> Irregular breathing during sleep	<input type="checkbox"/> Difficulty sleeping
Lungs:	<input type="checkbox"/>	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Other breathing difficulties	<input type="checkbox"/> Cough <input type="checkbox"/> Wheezing	<input type="checkbox"/> Pneumonia <input type="checkbox"/> Noisy breathing	<input type="checkbox"/> Asthma <input type="checkbox"/> Coughing blood
Gastrointestinal:	<input type="checkbox"/>	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Constipation	<input type="checkbox"/> Abdominal swelling <input type="checkbox"/> Bloody stools	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Black stools	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Jaundice
Genitourinary:	<input type="checkbox"/>	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Painful urination	
Menstrual:	<input type="checkbox"/>	<input type="checkbox"/> First day of last period _____	<input type="checkbox"/> Irregularity	<input type="checkbox"/> Pain/cramping	
Musculoskeletal:	<input type="checkbox"/>	<input type="checkbox"/> Scoliosis <input type="checkbox"/> Joint pain	<input type="checkbox"/> Other spine problems	<input type="checkbox"/> Joint swelling	<input type="checkbox"/> Joint redness
Endocrine:	<input type="checkbox"/>	<input type="checkbox"/> Heat/ cold intolerance	<input type="checkbox"/> Change in appetite	<input type="checkbox"/> Excessive thirst	
Hematologic:	<input type="checkbox"/>	<input type="checkbox"/> Anemia <input type="checkbox"/> Swollen glands	<input type="checkbox"/> Bruising	<input type="checkbox"/> Bleeding	<input type="checkbox"/> Blood clots
Neurologic:	<input type="checkbox"/>	<input type="checkbox"/> Seizures <input type="checkbox"/> Dizziness <input type="checkbox"/> Paralysis	<input type="checkbox"/> Headaches <input type="checkbox"/> Poor coordination <input type="checkbox"/> Weakness	<input type="checkbox"/> Numbness <input type="checkbox"/> Difficulty walking	<input type="checkbox"/> Tingling <input type="checkbox"/> Difficulty speaking
Psychologic:	<input type="checkbox"/>	<input type="checkbox"/> Depression <input type="checkbox"/> Nightmares	<input type="checkbox"/> Anxiety <input type="checkbox"/> Mood change	<input type="checkbox"/> Drug/ alcohol abuse <input type="checkbox"/> Attention deficit	<input type="checkbox"/> Phobias <input type="checkbox"/> Hyperactivity

Other concerns:
