



# Pediatric Heart Center of Central Oregon

## NEW PATIENT QUESTIONNAIRE

Please answer the following questions regarding the patient/child to be seen, if applicable:

Today's Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Age: \_\_\_\_\_

Guardian/Custodial Party(s): \_\_\_\_\_

Relationship to Patient:

- Mother       Father       Grandparent       Other \_\_\_\_\_  
 Stepmother       Stepfather       Foster parent(s)

What is the reason for your visit to The Pediatric Heart Center?

\_\_\_\_\_  
\_\_\_\_\_

Does the patient experience any of the following:

	NO	YES		NO	YES
Poor feeding (infants)	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
Exercise intolerance	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness/Lightheadedness	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Turning blue	<input type="checkbox"/>	<input type="checkbox"/>			

Do you have concerns about the patient's growth or development ?       No       Yes      If so, state concerns:

\_\_\_\_\_

### MEDICAL HISTORY:

Birth weight: \_\_\_\_\_ lbs \_\_\_\_\_ oz

Was this child premature?  No       Yes

If so, how many weeks? \_\_\_\_\_

During the pregnancy, did the child's **MOTHER**:

	NO	YES	DON'T KNOW
Take any medications other than vitamins/iron? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have any illnesses? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoke? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drink Alcohol? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use drugs not prescribed by a physician? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have any other pregnancy complications? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If applicable, please explain and boxes marked **YES**:

\_\_\_\_\_

Were there any problems during delivery or in the nursery?       No       Yes       Don't know

If yes, please describe:

\_\_\_\_\_

\_\_\_\_\_

Has the patient been hospitalized (please include surgical procedures)?  No  Yes  Don't know  
If yes, please explain (diagnosis, when, where):

\_\_\_\_\_

\_\_\_\_\_

Please list current medications and doses:

\_\_\_\_\_

\_\_\_\_\_

Allergies:  None  
 Drug allergies: \_\_\_\_\_  
 Other allergies: \_\_\_\_\_

Are the patient's immunizations up to date?  Yes  
 No Please explain: \_\_\_\_\_  
 Don't know

Please check if the patient has ever had the following:

EKG  Heart catheterization  Holter monitor  
 Echocardiogram  Chest x-ray  Cardiac event monitor  
 Exercise test (stress test)

If applicable, name of previous cardiologist(s): \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
(Please use back if additional space needed)

Has the patient been told to take antibiotics before dental procedures? ....  No  Yes  
Has the patient's activity been restricted by a physician? .....  No  Yes

**FAMILY HISTORY:**

Please list child's siblings, their ages, and any health problems:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have any family members (including aunts, uncles, cousins, grandparents) had (check all that apply):

Born with heart defect  Heart murmur  Heart attack *at age less than 55*  Asthma  
 Sudden death at *young age*  High cholesterol  Stroke *at age less than 55*  Other (please explain):  
 Heart rhythm abnormality  Fainting  Diabetes

**SOCIAL HISTORY:**

Patient's grade in school: \_\_\_\_\_ Name of school: \_\_\_\_\_  Home schooled

Who lives with patient?  Mother  Father  Stepmother  Stepfather  
 Other: \_\_\_\_\_

Please list occupations of parent(s)/guardian(s):

Father \_\_\_\_\_ Mother \_\_\_\_\_  
Stepfather \_\_\_\_\_ Stepmother \_\_\_\_\_  
Other, if applicable: \_\_\_\_\_

Is the patient active in sports?  No  Yes

If yes, which ones? \_\_\_\_\_

Does the patient...	NO	YES
drink alcohol ?.....	<input type="checkbox"/>	<input type="checkbox"/>
use drugs not prescribed by a physician ?.....	<input type="checkbox"/>	<input type="checkbox"/>
smoke/use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
use caffeine (coffee, tea, soda, energy drinks, pills)?	<input type="checkbox"/>	<input type="checkbox"/>

Does anyone at home smoke/use tobacco?

Note: Please mark "yes" if family members smoke "outside."

**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:

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