



# 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?

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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:

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### 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**:

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

If yes, please describe:

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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?	<input type="checkbox"/>	<input type="checkbox"/>

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