New Patient Medical Information Questionnaire

This questionnaire is designed to help the medical staff of ***Pediatric Cardiology Associates of Houston*** learn about you/your child's medical, social and developmental history. Health history is extremely important to us. **Please take the time to completely and fully answer the following questions** so we can be of better help to you/your child. Your answers are considered confidential. If any questions arise in filling out any portion of this questionnaire, please leave those spaces blank until you speak with the doctor.

Appt. Date_____ Patient Name_____Nickname _____
First Middle Initial Last

DOB_____ Age_____ Gender M F Primary Care Physician_____
Circle one

Why are you here today?_____

_____

Current Health Please check the best answer to each question below pertaining to the **patient.**

1. (For baby) On average, he/she will take _____ ounces at one feeding.
2. (For baby) It usually takes about _____ minutes for him/her to finish a bottle (or breast).
3. (For baby) He/she seems to easily get short winded or out of breath when bottle- or breast-feeding. ☐Yes ☐No
4. Overall, my/my child's current health is ☐very good ☐good ☐fair ☐poor.
5. Describe any cardiac-related symptoms or problems you feel you/your child might be having:

6. I am/My child is ☐very active ☐normally active for age ☐not very active.
7. I have/My child has ☐above normal physical endurance ☐normal endurance ☐poor endurance.
8. I seem/My child seems to get out of breath very easily with just usual activities. ☐Yes ☐No
9. I do/My child does vigorous physical activity/work/sports regularly. ☐Yes ☐No
10. I/My child can keep up with others when doing vigorous physical activity. ☐Yes ☐No
11. Overall, I am/my child is ☐often sick ☐not often sick.
12. I have/My child has a persistent or recurring problem with worrisome chest pain. ☐Yes ☐No
13. I have/My child has unusual skipping or irregularity of the heartbeat. ☐Yes ☐No
14. I have/My child has elevated blood pressure. ☐Yes ☐No
15. Normally my/my child's breathing pattern is ☐comfortable (normal) ☐often short of breath.
16. I have/My child has asthma. ☐Yes ☐No
17. My/My child's asthma is ☐mild ☐moderate ☐severe ☐not applicable.
18. I have/My child has a recurring problem with unusual racing of the heart. ☐Yes ☐No
19. I have/My child has a history of fainting spells (passing out). ☐Yes ☐No
    If yes, explain_____
20. I have/My child has a history of seizures or convulsions. ☐Yes ☐No
21. Overall, I consider my/my child's current weight to be ☐normal ☐underweight ☐overweight.
22. My/My child's appetite is ☐normal ☐fair ☐poor.
23. My/My child's weekly intake of caffeine is ☐none ☐minimal ☐moderate ☐heavy.
24. I have/My child has a proper daily habit of brushing the teeth. ☐Yes ☐No
25. I have/My child has been to the dentist in the past year. ☐Yes ☐No
26. I require/My child requires a dose of antibiotic one hour prior to any dental work, cleaning or surgery. ☐Yes ☐No

Recent symptoms or health issues of **patient**	**No**	**Yes**	**If yes, explain briefly**
1. Problem with general health, growth, development			
2. Unusual weight change			
3. Problem with eyes/vision			
4. Problem in area of head, ears, nose, sinuses, throat			
5. Problem with lungs/breathing			
6. Problem with stomach, digestion, intestinal system			
7. Problem in genital or urinary system			
8. Problem in muscles, joints, back, neck, bones			
9. Skin problem			
10. Chronic headaches, nerve problems			
11. Behavioral issues			
12. Problem with endocrine glands, lymph glands			
13. Unusual bleeding problem, anemia			
14. Immune system/HIV			
15. Allergies, hives, hayfever			
16. Unexplained fever			
17. Speech or hearing problem			

Check all allergies and describe any reactions below the category.

☐ None ☐ Seasonal ☐ Medications ☐ Food ☐ Dye ☐ Latex ☐ Other_____

_____

Have you ever.....	No	Yes	Explain briefly
Been hospitalized?			
Had a serious illness (hepatitis, meningitis, etc.)?			
Had surgery?			
Had any serious injury?			
Had any specific drug allergies?			
Had a blood transfusion?			
Had any medication intolerance (vomit, diarrhea)?			

Family History Please check all that apply to **patient's** family members.

	Father	Mother	Brother/ Sister	Paternal Grandparents	Maternal Grandparents	Other Family
Birth defect of the heart						
Heart attack or coronary artery disease						
Heart rhythm problem (arrhythmia)						
Heart disease						
Sudden unexplained death of a young person						
High cholesterol or triglycerides						
Mitral valve prolapse						
High blood pressure or stroke						
Serious problem with anesthesia						
Asthma, hayfever, serious allergies						
Bleeding disorder						
Diabetes, epilepsy, cancer, thyroid disease						

Please fill in name age and current health status of **patient's** primary family members. *Parents currently together ☐Yes ☐ No

Father	
Name	
Age	
Health	

Mother	
Name	
Age	
Health	

Patient	
Name	
Age	
Health	

Brother/Sister	
Name	
Age	
Health	

Brother/Sister	
Name	
Age	
Health	

Brother/Sister	
Name	
Age	
Health	

Brother/Sister	
Name	
Age	
Health	

Brother/Sister	
Name	
Age	
Health	

Family General Health and Safety

	Yes	No	N/A
Generally use lap and shoulder seat belts			
Use helmet for bicycle or all-terrain vehicle			
Avoid tobacco, alcohol, drug use			
Limit fat and cholesterol in diet			
Participate in vigorous physical activity at least three times a week			
Have dental appointment once or twice a year			
Currently up to date with immunizations			

Birth History of Patient

1. My mother was healthy during her pregnancy with me. ☐Yes ☐No
2. She had a full-term (9 months) pregnancy. ☐Yes ☐No
3. I was born at_____, _____, _____.
   Hospital City State
4. I weighed _____lbs.,_____oz. at birth.
5. I had medical problems during the first few days of my life. ☐Yes ☐No
   If yes, please give details_____.

Social History Please answer questions as pertaining to **patient**.

1. I handle my current educational program and/or work ☐very well ☐okay ☐have problems ☐not applicable.
2. I have behavioral or psychological problems. ☐Yes ☐No
3. I have problems with cigarette smoking ☐Yes ☐No Marijuana smoking ☐Yes ☐No
   Chewing tobacco ☐Yes ☐No Alcohol ☐Yes ☐No Drugs ☐Yes ☐No

Medications Please list all medications the **patient** is currently taking (or write **none**).

Medication	Strength of tablet or liquid	Dosage

Medication	Strength of tablet or liquid	Dosage

The above information is true and correct._____ I have reviewed this questionnaire. _____

Patient/Guarantor Signature Physician Signature