Children's Heart Specialists, PSC

Medical Information

Patient's Name: __________________________________ Date:________________

Parent's or Informant's Name:____
Relationship to the Patient:____

1. Is this your first visit to our office? Yes No

2. Reason for this visit (may check more than one);
____Heart Murmur (When was the first time detected?)________________________
____Chest Pain ____Failure to gain weight or grow
____High Cholesterol ____Dizzy
____Fainting (Syncope)
____Irregular heartbeats or abnormal heart rhythm
____Known heart defect (specify:____)
____Second Opinion (for:____)
____Other (specify:____)

3. Prenatal and natal history (to fill out if your child is under three years old):
a) ___Normal Pregnancy and delivery
___Abnormal pregnancy (prematurity, twins or other)
Specify: ____
b) ___Newborn complications (lung or heart problems or other)
Specify: ____
c) Birth weight: _____ pounds _____ ounces

4. Any recent symptoms? Please state: _______________________________________

a) Any weight loss lately?	**Yes**	**No**
b) Dental caries or infection?	**Yes**	**No**
c) Sore throat (when?___________)	**Yes**	**No**
d) Asthma?	**Yes**	**No**
e) Ear infection? (when?______________)	**Yes**	**No**
f) Skin rash?	**Yes**	**No**

5. Any previous serious illness? _________________________ Date: ____________

6. Any previous hospitalization?
Date:___________________________Reason: _______________________

Date: __________________________Reason: _______________________

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7. Any Allergies: **Yes** **No**
To: ____
Type of reaction? ____

8. If patient is an infant, How many ounces of formula (or milk) he/she takes:
Per feeding _______ ounces Name of formula: _________________
Per day: _________ ounces.

9. Is the patient active in sports? **Yes** **No**
a) Which ones?____
b) Competitive? **Yes** **No**
c) Any symptoms while playing? **Yes** **No**
d) Any other pertinent information or problem that the patient complains of?:
____
____

What medicines is the patient taking?_________________, _________________ ,
_________________, ____________________,____________________________

1. **Patient's Family History:**

a) Parents or siblings with heart problems during childhood? **Yes** **No**
Who?__________________________________ What type?_______________

b) First degree relatives (aunts, uncles, grandparents or cousins) with heart problems during childhood or before age 45? **Yes** **No**
Who?____

c) Adults with late heart problems (heart attacks, Other) **Yes** **No**
Who?____

d) High blood pressure in the family? **Yes** **No**
Who?____

e) Diabetes? **Yes** **No**
Who?__________________________uses Insulin?______________________

f) Sickle cell anemia or sickle cell trait? **Yes** **No**
Who?____

g) Sudden death (not accidental) in any close relative at age 35 or younger? **Yes** **No**

h) Mitral Valve Prolapse? **Yes** **No**

i) Cardiomyopathy (weak, thick or dilated heart) in close relative? **Yes** **No**

j) Other? Specify____

11. Tests which have been performed before coming to our office:

____ECG (electrocardiogram) **____Chest X-ray**
____ 24 hour ECG (Holter) **____Echocardiogram**
____Stress test **____Other (specify:__________)**

b) evaluation by a neurologist or any other specialist? **Yes** **No**
c) previous evaluation by another pediatric cardiologist? **Yes** **No**

FOR OFFICE USE ONLY

Dr Juan Villafañe reviewed history with patient/parents; **Yes** **No**