Pediatric Cardiology Associates **Fetal Patient Information Form**

Name: _____ **Date of Birth:** _____ **Age:** _____

Primary Obstetrician: _____**High-Risk Obstetrician:** _____

Reason for Cardiology evaluation today: _____

Estimated Date of Delivery: _____ **Gestational Age**: _____weeks

Infant's Gender: □ Male □ Female □ Do Not Know

Current pregnancy complications: _____

_____

Past Medical History: **(Please use back of sheet if necessary)**

Ongoing Medical Conditions:(example: Asthma, Diabetes, Hypertension)_____

Prior Hospitalizations? □ Yes □ No Explain: _____

Prior Surgeries? □ Yes □ No Explain: _____

Medicine/Allergies:

List of Current Medications**:** _____

Allergies to Medications**:** □ Yes □ No (If Yes, please list with reaction) _____

Review of System

(Please check if **the patient** has a history of any of the following)

General:	□ Weakness	□ Fatigue	□ Fever
	□ Chills	□ Unexplained Weight Loss	□ Unexplained Weight Gain
HEENT:	□ Eye Drainage	□ Trouble Seeing	□ Corrective Lenses
	□ Nasal Congestion	□ Hearing Issues	□ Ear Pain
	□ Sore Throat	□ Nosebleeds	□ Gum Bleeding
Cardio/Vasc:	□ Fast Heart Rate	□ Chest Pain	□ Murmur
	□ Irreg. Heart rate	□ Palpitations	
GI:	□ Diarrhea	□ Constipation	□ Nausea/Vomiting beyond first trimester

	□	□ Abdominal Pain	□ Blood in Stool
GU:	□ Frequent Urination	□ Blood in Urine	□ Spotting
	□ Contractions	□	□
Musculoskeletal	□ Joint Pain & Swelling	□ Muscle Pain	□ Stiffness
Derm:	□ Rash	□ Skin Sores	□ Hair Loss
	□ Nail Changes		
Neurological:	□ Weakness	□ Seizures	□ Numbness
Endo:	□ Excessive Thirst	□	□
Chest/ Pulmonary	□ Cough	□ Chest Tightness	□

_____ ***Date*_____**

Signature of Individual Completing Form

Relation to Patient: (Please check) □ Self □ Parent □ Partner

Date: _____ Reviewed by: _____MD