ROCKY MOUNTAIN PEDIATRIC CARDIOLOGY

PATIENT MEDICAL HISTORY

Patient Name _____ **Age** ____ **DOB** _____ **Date of Visit** _____

Please list all daily medications (and dosages):

Med	**Med**	**Med**	**For Office Use: Room#**
Dose	**Dose**	**Dose**	**HT: WT:**
Med	**Med**	**Med**	**BP: HR:**
Dose	**Dose**	**Dose**	**RESP: SP02:**

Please list any medication allergies or negative reactions to medications, if known:

_____

Please note if the patient has (or has had) significant problems with the following:

General		
Weakness / Fatigue	**Y**	**N**
Fever (frequent or prolonged)	**Y**	**N**
Poor Weight Gain	**Y**	**N**
Vision Problems / Glasses	**Y**	**N**
HEENT		
Nasal Congestion	**Y**	**N**
Hearing Problems	**Y**	**N**
Nosebleeds / Unusual Bleeding	**Y**	**N**
Sore Throat (unusual)	**Y**	**N**
Feeding Difficulties	**Y**	**N**
Swallowing Problems	**Y**	**N**
Head Injury	**Y**	**N**
Cardio/Vasc		
Fast Heart rate	**Y**	**N**
Chest Pain	**Y**	**N**
Irreg. Heart rate	**Y**	**N**
Poor Exercise Capability	**Y**	**N**
Excessive Sweating	**Y**	**N**
Fainting	**Y**	**N**
Heart Murmur	**Y**	**N**
Known or Suspected Heart Defect	**Y**	**N**
GI		
Diarrhea	**Y**	**N**
Constipation	**Y**	**N**
Nausea / Vomiting	**Y**	**N**
Stomach Pain	**Y**	**N**

GU		
Bladder / Kidney Problems	**Y**	**N**
Musculoskeletal		
Joint Pain / Swelling	**Y**	**N**
Back Pain / Muscle Pain	**Y**	**N**
Broken Bones	**Y**	**N**
Scoliosis	**Y**	**N**
Derm		
Rash / Skin Problems	**Y**	**N**
Neurological		
Seizures	**Y**	**N**
Headaches	**Y**	**N**
Endo/Metabolic		
Excessive Thirst	**Y**	**N**
Unexplained Weight Loss / Gain	**Y**	**N**
Chest/Pulm		
Cough	**Y**	**N**
Frequent Pneumonia	**Y**	**N**
Asthma	**Y**	**N**
Labored /Rapid Breathing	**Y**	**N**
Chest Trauma	**Y**	**N**
Other		
School / Behavioral Problems	**Y**	**N**
Difficulties at Birth / Premature Birth	**Y**	**N**
Need for Supplemental Oxygen	**Y**	**N**
Difficulty with Travel to Mountains	**Y**	**N**

If there are no changes from prior visits in family medical history, or patient hospitalizations or surgeries, you may indicate by checking here □ and proceed to any "worries or concerns" you may have. If this is a first time visit, please complete the remainder of the form.

Please note if any of the following exist in family members or close relatives (list the relatives):

Heart Attack / Heart Disease (CAD)before age 50	**Y N**	**_____**
High Blood Pressure (Hypertension)	**Y N**	**_____**
High Cholesterol / Triglycerides	**Y N**	**_____**
Birth Defects of the Heart (Congenital Heart Defects)	**Y N**	**_____**
Sudden Death	**Y N**	**_____**
Arrhythmia (Irregular Heart Rhythm)	**Y N**	**_____**
Cardiomyopathy (Dilated or Hypertrophic)	**Y N**	**_____**
Diabetes	**Y N**	**_____**

Please list any other medical conditions the patient has:

_____
_____
_____

Does any household member, baby sitter, or patient smoke cigarettes? Y N _____

Are immunizations current: Y N

Patient lives with … Mother Father Both Other_____

Please list any Hospitalizations/Surgeries (Please give dates)

_____
_____
_____
_____
_____

Please list any specific worries or concerns that you may have about the patient's health:

_____
_____
_____
_____
_____