PEDIATRIC CARDIOLOGY ASSOCIATES

PEDIATRIC HEALTH HISTORY SYSTEMS REVIEW

Today's Date:	Patient Name:	Date Of Birth:	M F
Parents: Father's Name:		Mothers Name:	
Legal Guardian's Name:			

If The Patient Is Less Than Five (5) Years Old, Please Answer The Pregnancy & Birth Questions:

Were there any problems during the mother's pregnancy? ☐ **NO** ☐ **YES** If YES, please describe.

Were there any problems during labor or delivery? ☐ **NO** ☐ **YES If** YES, please describe.

How was the baby delivered? ☐ Vaginally ☐ Assisted vaginal delivery ☐ C-section If C-section, why?

How many weeks pregnant was mother when the baby was born?

What was the baby's weight at birth?

Were there any problems during the nursery stay? ☐ **NO** ☐ **YES**

If yes, please describe: ☐ **Extended Nursery Stay** ☐ **Nasal Oxygen** ☐ **Feeding Difficulties** ☐ **Mechanical Ventilator**

ILLNESSES AND OTHER PROBLEMS:

Hospital Stays and/or Serious Illness

Date:	Hospital:	Problem:
Date:	Hospital:	Problem:
Date:	Hospital:	Problem:

Operations And/Or Accidents

Date:	Describe:
Date:	Describe:
Date:	Describe:

CHRONIC MEDICAL CONDITIONS:

Any Chronic Medical Conditions? ☐ **No** ☐ **Asthma** ☐ **Diabetes** ☐ **Sickle Cell** ☐ **ADD** ☐ **ADHD** ☐ **OTHER**

If OTHER, please describe:

MEDICATIONS:

Please list all prescription medications that your child is currently taking, include strength/dosage as well as frequency.
Please include over-the-counter medicines also. ☐ **NO PRESCRIPTION MEDICATIONS**

#1

#2

#3

#4

#5

#6

Patient Name : ______________________ Date: ______________

ALLERGIES:

Please list any Allergies to Medications or Foods: ☐ NO KNOWN DRUG ALLERGIES

#1

#2

#3

IMMUNIZATIONS:

Are Immunizations Current? ☐ YES ☐ NO If NO, please describe:

FAMILY HISTORY:

Is the patient adopted? ☐ NO ☐ YES

Please identify any of the following that a family member or relative may have. Write which family member has the condition:

	Congenital Heart Defects		Long QT Syndrome		High Blood Pressure
	Sudden Unexplained Death		Dilated Cardiomyopathy		Diabetes
	SIDS or Sudden Infant Death		Hypertrophic Cardiomyopathy		Asthma
	Heart Rhythm Problems		Heart attacks before 50 years old ((		High Cholesterol or Hyperlipidemia

Immediate Family Members

Member	DOB	Healthy Y/N	Problems
Mother		☐ Yes ☐ No	
Father		☐ Yes ☐ No	
Brother		☐ Yes ☐ No	
Brother		☐ Yes ☐ No	
Brother		☐ Yes ☐ No	
Sister		☐ Yes ☐ No	
Sister		☐ Yes ☐ No	
Sister		☐ Yes ☐ No	

Are Father and Mother and all brothers and sisters alive? ☐ Yes ☐ No

SOCIAL HISTORY:

Patient Lives With? (Check All That Apply):
☐ Mother ☐ Father ☐ Brother(s) ☐ Sister(s) ☐ Grandparents ☐ Others:

Pets in the household? ☐ No ☐ Yes If yes, list types of pets:

Grade In School; including daycare:

If finished with school and now working, list employer and occupation:

Patient exercises: ☐ Regularly ☐ Occasionally ☐ Restricted or Unable to exercise
List types of exercise that are usually done, including any team sports:

Does anyone in the household smoke? ☐ No ☐ Yes If yes, who:

If the patients is 13 years or older, do they use any tobacco products? ☐ No ☐ Yes If yes, please list products used:

If the patient is 18 years old or older, do they have any Advanced Directives? ☐ None
☐ DNR ☐ HC Proxy ☐ Refused ☐ No Life Support ☐ DPA ☐ Living Will

GENERAL REVIEW OF SYSTEMS:

Patient Name : ______________________________ Date: ____________________

Please Note If The Patient Has Any of The Following:

General: □ None □ appetite change □ activity change □ fever □ irritability □ lethargy □ poor weight gain □ trouble sleeping	**Cardiovascular: □ None** □ chest pain □ cool extremities □ color change □ easy fatigability □ excessive sweating □ fainting □ fast heartbeat □ irregular heartbeat □ murmur □ palpitations □ high cholesterol*	**Ears/Nose/Throat: □ None** □ gum bleeding □ hearing loss □ nasal congestion □ noisy breathing □ nose bleeds □ sleep apnea □ tooth pain
Endocrine: □ None □ excessive weight gain □ slow growth □ weight loss □ excessive thirst or urination*	**Eyes: □ None** □ blurred vision □ corrective lenses □ eye drainage □ eye redness □ lazy eye	**Gastrointestinal: □ None** □ abdominal distension □ abdominal pain □ blood in stool □ constipation □ diarrhea □ eating problems □ reflux symptoms/heartburn □ vomiting
Genitourinary: □ None □ blood in urine □ decreased urination □ frequent urination	**Hematologic/Lymphatic: □ None** □ bleeding problems □ easy bruising □ swollen glands	**Musculoskeletal: □ None** □ bone deformity □ joint pain □ joint swelling □ muscle aches □ scoliosis □ swelling of extremities
Neurologic: □ None □ dizziness □ headaches □ seizures □ weakness	**Psychiatric: □ None** □ depression □ hyperactivity/ADD/ADHD □ mood swings □ nervousness or anxiety □ school problems □ sleep disturbance	**Respiratory: □ None** □ asthma symptoms □ chronic cough □ recurrent wheezing □ shortness of breath with exercise □ snoring □ frequent pneumonia
Skin: □ None □ birthmarks or hemangiomas □ cyanosis □ eczema □ nail changes □ pallor □ rash		

Relationship of Individual Completing This Form To Patient ☐ Patient ☐ Parent ☐ Guardian

Signature:

[For office use only--*Medical Assistant will enter under Additional Comments in computer system]

PCA Associate:

Reviewed By: MD/ARNP Date: