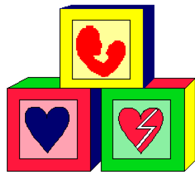

Pediatric Cardiology Associates

PEDIATRIX CARDIOLOGY

PEDIATRIC HEALTH HISTORY SYSTEMS REVIEW

Today's Date/*Fecha*:	Patient Name/*Nombre del Paciente*:	Date Of Birth: *Fecha de Nacimiento*:	M F
Parents: Father's Name/*Padre*:		Mothers Name/*Madre*:	
Legal Guardian Name:			
If The Patient Is Less Than One Year Old, Please Answer Section A			

A) PREGNANCY/BIRTH (Please describe any YES answers)/*Nacimiento e Historia Medica*		
Were there any problems during the mother's pregnancy?/*Embarazo Problemas Medicos?* ☐ **NO** ☐ **YES**		
How many weeks pregnant was mother when the baby was born?/*No. semanas?*		
Were there any problems during labor or delivery?/*Problemas Parto* ☐ **NO** ☐ **YES**		
Was the baby delivered by c-section or vaginally? ☐ c-section/*Cesarea* ☐ vaginally/*Vaginal*		
Any problems during the nursery stay? */Problemas en "Nursery"?* **NO** ☐ **YES**		
What was the baby's weight at birth?/*Peso?*		
Where there any difficulties feeding? ☐ **NO** ☐ **YES**		
B) ILLNESSES AND OTHER PROBLEMS/*Historia Medica (Pasada)*		
Hospital Stays and Serious Illness/*Hospitlizaciones/Enfermedades*		
Date:	Hospital:	Problem:
Date:	Hospital:	Problem:
Date:	Hospital:	Problem:
Operations And/Or Accidents/*Cirugias*		
Date:	Describe/*Razon*:	
Date:	Describe/*Razon*:	
Date:	Describe/*Razon*:	
Chronic Medical Conditions/*Enfermedades Cronicas*		
Any Chronic Medical Conditions ☐ **No** ☐ **Asthma** ☐ **Diabetes** ☐ **Sickle Cell** ☐ **Other:**		
C) 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 MEDICINES		
Name:	**Dose :**	**Frequency:**
#1		
#2		
#3		
#4		
#5		

Patient Name:_________________________________Date:________

D) Allergies Please list Any Allergies to Medications Foods /Alergias *Medicamentos/Otro* ☐ None Known
E) Are Immunizations Current? <u>Vacunas Al Dia</u> ☐ Yes ☐ No If No, please describe/*Razon*:

F) FAMILY HISTORY Please identify any of the following that a family member or relative may have/*Marque las siguientes enfermedadeas encontrades en miembros de la familia*

	Congenital Heart Defects		**Heart attacks before 50 years**		**Asthma or wheezing/*Asma***
	Sudden unexplained death		**High Cholesterol/*Colesterol Alto***		**High Blood Pressure/*Alta Presion***
	SIDS or infant death/ *Muerte subita de Infantes*		**Heart Rhythm Problems**		**Diabetes/*Diabetis***
	Cardiomyopathy		**Long QT syndrome**		**Anemia/Blood Diseases/ *Enfermedaldes de la Sangre***

Immediate Family Members

Member	DOB	Healthy Y/N	Problems
Mother/*Madre*		☐ Yes ☐ No	
Father/*Padre*		☐ Yes ☐ No	
Child/*Hijo*		☐ Yes ☐ No	
Child/*Hijo*		☐ Yes ☐ No	
Child/*Hijo*		☐ Yes ☐ No	
Child/*Hijo*		☐ Yes ☐ No	
Child/*Hijo*		☐ Yes ☐ No	
Child/*Hijo*		☐ Yes ☐ No	

Are All Father and Mother brothers and sisters alive? ☐ **Yes** ☐ **No**

G) SOCIAL HISTORY

Patient Lives With? Check All That Apply: ***Quien vive con el nino/nina?***

☐ **Mother** ☐ **Father** ☐ **Brother(s)** ☐ **Sister(s)** ☐ **Grandparents** ☐ **Others**

Grade In School: ***Grado***

H) GENERAL REVIEW OF SYSTEMS/*Sistemas*

Please Note If The Patient Has Any of The Following/Marque Si o No en todas los que apliquen a su nino

General: □ **None**	**Allergy/Immunology:** □ **None**	**Endocrine:** □ **None**
□ poor weight gain □ recent weight loss □ frequent fevers/*Fiebre* □ fatigue (tiredness)/*Fatiga* □ paleness	□ seasonal or chronic runny nose □ watery eyes □ nasal congestion/*Congestion Nasal* □ sneezing □ frequent infections	□ heat or cold intolerance □ excessive urination □ excessive sweating □ diabetes □ excessive thirst/ hunger
Respiratory/*Respiratorio*: □ **None**	**Skin/*Piel*:** □ **None**	**Neurologic:** □ **None**
□ wheezing/*Sibilancia (Pito)* □ coughing □ chest pain □ noisy breathing	□ eczema/*Eczema* □ rashes □ itching □ dryness □ hemangiomas/birthmarks	□ speech problems □ headaches/*Migrana* □ seizures/*Convulsiuones* □ weakness □ school problems

Patient Name:__________________________________Date:________

Gastrointestinal: □ None	**Ears/Nose/Throat: □ None**	**Musculoskeletal/Sistema Muscular: □ None**
□ coughing/choking/gagging w/eating □ frequent vomiting □ constipation □ frequent diarrhea/loose stools □ frequent heartburn/stomach aches □ blood in stool	□ ear infections □ ear drainage □ weak cry □ hearing loss □ sinus trouble/frequent infections □ nosebleeds/*Sangrado de Nariz*	□ muscle pain □ limp □ recent trauma/fractures □ joint pain or stiffness □ joint/muscle swelling

Cardiovascular: □ None	**Eyes/*Ojos*: □ None**	**Genitourinary/*Genital*: □ None**
□ heart murmur/soplo □ chest pain □ blue spells □ high blood pressure/ *Alta Presion* □ swelling in hands/feet □ palpitations (fluttering in heart fast beats) □ syncope (passing out) □ high cholesterol/ *Colesterol Alto*	□ glasses/contact lenses/vision changes □ eye pain □ eye redness	□ pain or burning with Urination/*Dolor al Orinar* □ problems with menstruation
Hematologic/Lymphatic/*Sangre*: □ None □ anemia/*Anemia* □ enlarged lymph nodes/Glandulas Engrandecidas □ easy bruising/bleeding/ Sangra Facilmente	**Psychiatric/*Siquiatrico*: □ None** □ mood swings □ depression/*Depresion* □ nervousness □ sleep disturbance □ temper outbursts	

Relationship of Individual Completing This Form To Patient /*Completado Por:Relacion* ☐ Patient ☐ Parent ☐ Guardian
Signature:
PCA Associate
Reviewed By: MD/ARNP Date: