CENTER FOR PEDIATRIC & FETAL CARDIOLOGY OF SOUTH FLORIDA
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PRACTICE LIMITED TO CARDIOVASCULAR DISEASES IN THE FETUS, INFANTS, CHILDREN AND YOUNG ADULTS

MEDICAL INFORMATION

Date:_____

Name:_____Dob:_____

PERSONAL MEDICAL HISTORY

1. **Diabetes**	**YES ( )**	**NO ( )**
2. **Hypertension**	**YES ( )**	**NO ( )**
3. **Heart disease**	**YES ( )**	**NO ( )**
4. **Kidney Disorders**	**YES ( )**	**NO ( )**
5. **Seizures Disorders**	**YES ( )**	**NO ( )**
6. **Psychiatric Disorders**	**YES ( )**	**NO ( )**
7. **Lupus / Autoimmune Disorders**	**YES ( )**	**NO ( )**
8. **Asthma**	**YES ( )**	**NO ( )**
9. **Any other Disorders**	**YES ( )**	**NO ( )**
10. **Medications**	**YES ( )**	**NO ( )**

Last Menstrual Cycle date _____
Blood Type _____
Allergies to Medication _____
Have you had any surgeries **YES ( ) NO ( )**
Type of surgeries _____
Are you currently on any medications **YES ( ) NO ( )**
Do you smoke? **YES ( ) NO ( )**
Do you drink? **YES ( ) NO ( )**
Do you take recreational drugs? **YES ( ) NO ( )**
Are there any reported cases of mental retardation, learning disabilities or birth defects on either side of the family **YES ( ) NO ( )**

Patient Signature _____
(According to the AIUM and ultrasound examination does not guarantee a normal baby)