BAILLIARD HENRY PEDIATRIC CARDIOLOGY

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Your Name: _____ **Relationship to Patient:** _____

Patient Name: _____ **Date of Birth:** _____

Patient Preferred Name: _____ ☐ Male ☐ Female

Today's Date: _____ **Reason for Visit**: _____

SOCIAL HISTORY:

Brother(s) and age(s):_____ Sister(s) and age(s):_____

Who lives in the home with the patient? _____

During the daytime, the patient is: ☐ home ☐ daycare ☐ school (grade ____)

Type and frequency of physical activity: _____

Activities/Hobbies: _____

Smoking at home occurs: ☐ none ☐ outside the house ☐ inside the house

Patient smokes: ☐ yes, how much _____ ☐ no

Pets: ☐ inside ☐ outside; type: _____

FAMILY HISTORY:

Do you have any of these problems in the family? **IN WHOM?**

☐ Stillbirths
☐ SIDS or infant death under 1 year of age
☐ Unexplained deaths, drownings, death during sleep or during childbirth

☐ Children born with heart defects
☐ Children born with deafness
☐ Heart surgery in children

☐ Mitral valve prolapse
☐ Bicuspid aortic valve

☐ Seizure disorders
☐ Fainting

☐ Fast or irregular heart rates **(PLEASE CIRCLE)**

☐ Dilated cardiomyopathy (enlarged heart)
☐ Hypertrophic cardiomyopathy (thick heart)

☐ Pacemaker/defibrillator before 55 yrs of age
☐ Heart attack before 55 yrs of age
☐ Hypertension
☐ Abnormal cholesterol

☐ Thyroid disease
☐ Migraines
☐ Lupus
☐ Cancer (type) _____

☐ other _____
☐ none of the above

PAST MEDICAL HISTORY:

Birth: ☐ Full term ☐ Premature (<36 weeks) ☐ Vaginal delivery ☐ C-section **Birth weight**: _____

Hospitalizations: ☐ no ☐ yes (date, reason, location) _____

Emergency room visits: ☐ no ☐ yes (date, reason, location) _____

Surgeries: ☐ no ☐ yes (date, reason, location) _____

Previous visits to cardiology: ☐ no ☐ yes (date, reason, location) _____

Visits to other specialists: ☐ no ☐ yes (date, reason, location) _____

Immunizations up to date: ☐ no ☐ yes

Medications: ☐ no ☐ yes (type, length of treatment) _____

Allergies to medications: ☐ no ☐ yes (describe) _____

Does your child have any of the following? Check all that apply.

☐ Growth difficulty
☐ Abnormal weight loss or gain **(PLEASE CIRCLE)**
☐ Difficulty with breast or bottle feeding
☐ Frequent fevers
☐ Recent fevers or infection

☐ Blurred vision
☐ Deafness

☐ Heart murmur
☐ Palpitations or irregular heartbeat
☐ Chest pain
☐ Blueness of tongue/gums or trunk
☐ Dizziness/Light headedness
☐ Fainting
☐ Difficulty with play or exercise

☐ Shortness of breath
☐ Frequent wheezing or asthma
☐ Chronic cough
☐ Frequent pneumonia

☐ Gastroesophageal reflux
☐ Abdominal swelling
☐ Abdominal pain
☐ Diarrhea or constipation **(PLEASE CIRCLE)**

☐ Frequent urinary tract infection
☐ Blood in urine
☐ Abnormal periods

☐ Temperature intolerance
☐ Excessive sweating
☐ Difficulty moving extremities

☐ Swelling of hands or feet
☐ Peeling of hands/feet/nailbeds

☐ Abnormal muscle tone
☐ Seizures
☐ Frequent headaches

☐ Chronic rash
☐ Joint pain or joint swelling
☐ Unexpected or excessive bleeding/bruising

☐ Depression or anxiety **(PLEASE CIRCLE)**
☐ Learning disability
☐ ADD or ADHD **(PLEASE CIRCLE)**

☐ None of the above
☐ Other _____

Any additional concerns?

Signature: _____