ATTACH PATIENT LABEL HERE

HEART CENTER CLINIC
1200 CHILDREN'S AVENUE, SUITE 2F
OKLAHOMA CITY, OK 73104
PHONE: 405.271.5530

New Patient Questionnaire (please print)

PATIENT NAME	**DATE OF BIRTH**	**AGE**	**GENDER (M/F)**

PRIMARY CARE OR REFERRING PHYSICIAN NAME	**CITY**	**STATE**	**PHONE**

PLEASE LIST THE REASON(S) THE PATIENT HAS BEEN REFERRED TO BE EXAMINED BY A PEDIATRIC CARDIOLOGIST

Birth History: (for patients less than 5 years of age)

Weight		lbs		ozs	Length		inches
Full-Term Pregnancy:	☐ Yes	☐ No				
If premature, gestation period		weeks				
List any complications during pregnancy:						

Previous Cardiac Testing: (please check all that apply)

☐ Chest X-Ray	☐ Echocardiogram
☐ Cardiac Catheterization	☐ Electrocardiogram
☐ Cardiac CT (Cat Scan)	☐ Electrophysiology Study
☐ Cardiac MRI	☐ Event/Holter Monitor
☐ Other (specify):	

Household: (list all individuals living in the patient's home)

Name	Age	Relationship to Patient	Current Health Problems

Family and Social History:

Lives with both biological parents	☐ Yes	☐ No	Full or part-time employment	☐ Yes	☐ No
Lives with adoptive parent(s)	☐ Yes	☐ No	Needs medical clearance for work	☐ Yes	☐ No
Lives with foster family	☐ Yes	☐ No	List type of employment and any physical requirements below:		
Attends daycare or pre-school	☐ Yes	☐ No			
Attends school (grades K-12 or college)	☐ Yes	☐ No	Consumes energy drinks	☐ Yes	☐ No
Need medical clearance for return to school	☐ Yes	☐ No	Utilizes tobacco (including smokeless)	☐ Yes	☐ No
Participates in athletic activities/sports	☐ Yes	☐ No	Utilizes alcohol or drugs	☐ Yes	☐ No
Needs medical clearance for athletics	☐ Yes	☐ No	Needs social services or financial assistance	☐ Yes	☐ No

Allergies:

☐ Yes (if allergic to drugs, foods, or latex list below) ☐ No known drug, food or latex allergies

Medications

Preferred Pharmacy (list name & phone)

Drug Name	Dosage	Frequency Given	Drug Name	Dosage	Frequency Given
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Hospitalization and Surgery:

Year	Age	List reason for admission to hospital and/or type of surgery performed	Any complications?	
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No
			☐ Yes	☐ No

Family Medical History:

☐ Family health history unknown ☐ No family members have ever been treated for these problems

Are we currently providing care to a family member? ☐ Yes ☐ No If yes, list relationship: ____

Check the appropriate boxes below to indicate which family member(s) received care and treatment for any of these problems in the past.

Health Problem(s):	Mother	Father	Sister(s)	Brother(s)	Others	List the names of the "others"
Arrhythmias	☐	☐	☐	☐	☐	
Bleeding Disorder	☐	☐	☐	☐	☐	
Enlarged Heart	☐	☐	☐	☐	☐	
Congenital Heart Disease	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	
Heart Transplant	☐	☐	☐	☐	☐	
Elevated Cholesterol	☐	☐	☐	☐	☐	
Hypertension	☐	☐	☐	☐	☐	
Marfan's Syndrome	☐	☐	☐	☐	☐	
Prolonged QT	☐	☐	☐	☐	☐	
Sudden Unexplained Death	☐	☐	☐	☐	☐	
Health History Unknown	☐	☐	☐	☐	☐	

Review of Systems: (please mark any of the following that the patient is currently receiving care or treatment for)

Ears/Nose/Throat	**Cardiovascular**	**Endocrine (Glands)**	**Sleep**
☐ Hearing changes	☐ Heart Murmur	☐ Thyroid problems	☐ Awakening at night
☐ Ear infections	☐ Dizziness	☐ Poor growth	☐ Insomnia
☐ Sinus Problems	☐ Chest pain	☐ Diabetes	☐ Sleep apnea
Gastric (Stomach)	☐ Palpitations (heart racing)	**Neurologic (Brain)**	**Developmental**
☐ Constipation	☐ Passing out	☐ Developmental delay	☐ Speech
☐ Diarrhea	☐ Abnormal energy level	☐ Headaches	☐ Communication
☐ Vomiting/spitting up	☐ Abnormal exercise capacity	☐ Seizures	☐ Vision
☐ Abdominal pain	**General**	☐ ADHD (hyperactivity)	☐ Social
☐ Nausea	☐ Profuse sweating	☐ Numbness	☐ Motor
☐ Reflux	☐ Fever	☐ Weakness	**Genital/Urinary System**
☐ Feeding difficulties	☐ Malaise	☐ Tremors	☐ Painful urination
☐ Sweating with feeds	☐ Weight loss	**Breathing/Lungs/Chest**	☐ Blood in urine
Eyes	☐ Change in energy level	☐ Coughing	☐ Frequency
☐ Vision changes	**Musculoskeletal**	☐ Wheezing	☐ Bladder control
☐ Eye pain	☐ Joint pain	☐ Strider	**Psychiatric**
☐ Itching	☐ Swelling	☐ Shortness of breath	☐ Depression
Skin	☐ Stiffness	☐ Breathing difficulties	☐ Anxiety
☐ Skin Rash	☐ Abnormal weight bearing	☐ Breath difficulty with exertion	
☐ Easy bruising			

FORM COMPLETED BY (Name)	DATE COMPLETED	RELATIONSHIP TO PATIENT