Pediatric Cardiology of Long Island

FETAL ECHOCARDIOGRAM INTAKE FORM
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Date of Visit: _____

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

Race: ☐American Indian or Alaskan Native ☐Asian ☐Black or African-American ☐More Than One Race
☐Native Hawaiian ☐Other Pacific Islander ☐White ☐Refused to Report/Unreported

Ethnicity: ☐Hispanic or Latino ☐Non-Hispanic or Latino ☐Refused to Report/Unreported

Language: ☐English ☐Spanish ☐Other: _____

REASON FOR COMING TO THE DOCTOR TODAY:

Reason for fetal echocardiogram: _____

_____

PREGNANCY HISTORY: *Please describe the patients:*

CURRENT Gestational age: (how many weeks are you now): _____

TOTAL number of times you have been pregnant including this one: _____

How many children do you have and were they born: Premature:_____ Full term:_____

Current pregnancy complications: ☐None _____ ☐Other:

PAST MEDICAL HISTORY: *Has the patient ever been diagnosed with any of the following (currently or in the past):*

☐ADD	☐Anemia	☐Cancer	☐Down Syndrome	☐High Cholesterol
☐ADHD	☐Anxiety	☐Diabetes	☐Genetic Problem	☐Seizures
☐Allergies	☐Asthma	☐Depression	☐High Blood Pressure	☐Thyroid Problem

☐Other: _____

_____

_____

ALLERGY HISTORY:

☐**None** ☐ **NKDA (No Known Drug Allergies)**

☐Acetaminophen (Tylenol) ☐Aspirin ☐Iodinated Contrast Media ☐Penicillin ☐Sulfa Drugs

☐Other: _____

_____

MEDICATION HISTORY: *List any prescription or over the counter medications, vitamins, minerals, and herbals that you (the patient) are **currently** taking:*

☐**Not currently taking any medications**

Name of Medication	**Dosage**	**Name of Medication**	**Dosage**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY:

Has a member of the patient's family (parents, siblings, grandparents, aunts, uncles, cousins) been diagnosed with any of the following conditions (include deceased family members)? *Place an "X" under the family member with the condition, and indicate if the family member passed away due to that condition.*

	Mother	Father	Sibling(s)	Grandparent(s)	Other
☐ Aneurysms					
☐ Arrhythmia					
☐ Cardiomyopathy					
☐ Congenital Heart Defect					
☐ Deafness at birth					
☐ Diabetes					
☐ Enlarged Heart					
☐ Heart Attack < age 50					
☐ Heart Disease as adult					
☐ Heart Surgery					
☐ High Blood Pressure					
☐ High Cholesterol					
☐ Irregular Heart Beats					
☐ Lupus					
☐ Marfan Syndrome					
☐ Mitral Valve Prolapse					
☐ Pacemaker/Defibrillator					
☐ Prolonged QT Syndrome					
☐ Stillbirths					
☐ Stroke					
☐ SIDS					
☐ Sudden/Accidental Death					
☐ Syncope/Passing out					
☐ Tachycardia					
☐ Valve Leak/Narrowing					

☐Other: _____

SOCIAL HISTORY:

Who lives in your home with you: _____

Please describe your (the patient's) *current* Tobacco Use?

☐Current every day smoker ☐Current some day smoker ☐Former Smoker ☐Never Smoked ☐Unknown

Tobacco/Smoke 2nd hand Exposure Details: ☐None ☐Minimal ☐Frequent ☐Daily

Have you (the patient) used any illicit drugs during the pregnancy? ☐Yes ☐No

If yes, please indicate what type of drug and how often: _____

Have you (the patient) consumed any alcohol during the pregnancy? ☐Yes ☐No

If yes, please indicate what type of beverage and how many servings per day: _____

Have you (the patient) consumed any caffeine during the pregnancy? ☐Yes ☐No

If yes, please indicate what type of beverage and how many servings per day: _____

Please describe your (the patient's) current exercise routine: ☐Inactive ☐Light ☐Moderate ☐Heavy ☐Vigorous

REVIEW OF SYSTEMS:

Has the patient recently experienced any of the following symptoms? *Please mark either Yes or No for each of the items below*. Your doctor will discuss any positive responses with you.

General:	Yes	No
• Easy Fatigue	☐	☐
• Frequent Infections	☐	☐
• Paleness	☐	☐
• Poor Weight Gain	☐	☐
• Recent Weight Loss	☐	☐
• Recent Weight Gain	☐	☐

Skin:	Yes	No
• Abnormal Color: Blue or Very Pale	☐	☐
• Eczema	☐	☐
• Hemangiomas/Birthmarks	☐	☐
• Prominent Veins	☐	☐
• Rash	☐	☐

Cardiovascular:	Yes	No
• Blueness	☐	☐
• Chest Pain	☐	☐
• Dizziness	☐	☐
• Easy Fatigue	☐	☐
• Heart Murmur	☐	☐
• High Blood Pressure	☐	☐
• High Cholesterol	☐	☐
• Irregular Heart Beat	☐	☐
• Low Blood Pressure	☐	☐
• Palpitations or Rapid Heart Beat	☐	☐
• Passing Out	☐	☐
• Poor Exercise Tolerance	☐	☐

Gastrointestinal:	Yes	No
• Coughing/ Choking when Eating	☐	☐
• Difficulty Feeding	☐	☐
• Frequent Diarrhea	☐	☐
• Frequent Vomiting	☐	☐
• Heartburn/Stomach Aches	☐	☐
• Poor Eater	☐	☐

HEENT:	Yes	No
• Blurry Vision	☐	☐
• Cracked/Sore/Red Lips	☐	☐
• Ear Pain	☐	☐
• Glasses/Contact Lenses	☐	☐
• Hearing Loss	☐	☐
• Loss or Change of Vision	☐	☐
• Nasal Congestion	☐	☐
• Nosebleed	☐	☐
• Pink/Red Eyes	☐	☐
• Seasonal/Chronic Runny Nose	☐	☐
• Sore Throat	☐	☐
• Watery Eyes	☐	☐

Genitourinary:	Yes	No
• Blood in Urine	☐	☐
• Decreased Urine	☐	☐
• History of Urinary Tract Infections	☐	☐
• Painful Urination	☐	☐

Musculoskeletal:	Yes	No
• Chest Cavity Abnormality	☐	☐
• Joint or Muscle Pain	☐	☐
• Joint or Muscle Swelling	☐	☐
• Loose/Flexible Joints	☐	☐
• Redness/ Inflammation of Joints	☐	☐
• Scoliosis	☐	☐

Hematology:	Yes	No
• Anemia	☐	☐
• Easy Bruising/Bleeding	☐	☐
• Swollen/Enlarged Lymph Nodes	☐	☐

Neck:	Yes	No
• Neck Pain	☐	☐
• Neck Stiffness	☐	☐
• Neck Swelling	☐	☐

Respiratory:	Yes	No
• Asthma	☐	☐
• Chest Pain	☐	☐
• Difficulty Breathing	☐	☐
• Frequent Coughing	☐	☐
• Lung Collapse	☐	☐
• Noisy Breathing	☐	☐
• Pneumonia	☐	☐
• Shortness of Breath	☐	☐
• Wheezing	☐	☐

Psychiatric:	Yes	No
• Depression	☐	☐
• Mood Swings	☐	☐
• Nervousness	☐	☐
• Temper Outburst	☐	☐

Endocrine/Glands:	Yes	No
• Excessive Sweating	☐	☐
• Excessive Thirst/Hunger	☐	☐
• Heat or Cold Intolerance	☐	☐

Neurological:	Yes	No
• Abnormal Movements	☐	☐
• Diagnosis of ADHD/ADD	☐	☐
• Difficulty Speaking	☐	☐
• Headaches	☐	☐
• Numbness	☐	☐
• Seizures	☐	☐
• Weakness	☐	☐

Form Filled Out By:

☐Patient, ☐Mother, ☐Father, ☐Relative: _____, ☐Staff: _____, ☐Translator: _____

Physician Review: _____ **Date:** _____

☐AMV ☐SGL ☐DML ☐NM