Pediatric Cardiology of Long Island

# FOLLOW-UP VISIT PATIENT INTAKE FORM
(Page 1 of 2)

**Date of Visit:** _____

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

## REASON FOR COMING TO THE DOCTOR TODAY:

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

_____

## Current Medications (List all including non-prescription drugs, vitamins, etc): _____

_____

_____

## Medical/Surgical History:

| **Since the last visit here has the patient:** | **Yes** | **No** |
|---|---|---|
| Been diagnosed with a new medical problem or had a change in an existing medical problem | ☐ | ☐ |
| Been admitted to the hospital or had an unexpected visit to the doctor or emergency room | ☐ | ☐ |
| Had surgery or any other procedure | ☐ | ☐ |
| Started seeing a new primary doctor, specialist, therapist | ☐ | ☐ |

**If you answered "Yes" above, please explain:** _____

_____

_____

## Family History:

| **Since the last visit here, has anyone in the patient's family developed or been born with a new significant heart problem** | **Yes** | **No** |
|---|---|---|
| | ☐ | ☐ |

**If you answered "Yes" above, please explain:** _____

_____

_____

## SOCIAL HISTORY:

Please describe the patient's immediate family members? ☐Mother ☐Father ☐Brother(s)_____ ☐Sister(s)_____

Other (list): _____

Please describe your (the patient's) *current* School Status? ☐Regular school ☐Special education ☐Full-time ☐Part-time

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

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

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

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

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

Do you (the patient) drink alcoholic beverages? ☐Yes ☐No

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

Do you (the patient) drink caffeinated beverages? ☐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

# INITIAL VISIT PATIENT INTAKE FORM (Page 2 of 2)

## 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