Pediatric Cardiology of Long Island

INITIAL VISIT PATIENT INTAKE FORM
(Page 1 of 4)

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 Today's Visit: _____
Timing/Onset: When did symptoms first occur? _____
Duration: Frequency of symptoms? _____
Characterized as/Severity: In your own/your child's words, describe the symptoms/pain. _____
_____
Associated Signs and Symptoms: Are there any other symptoms associated with your problem? _____
_____
Modifying Factors: What makes the condition better and/or worse? _____
_____

BIRTH HISTORY: *Please describe the patients:*

Gestational age: ☐Pre-term (how many weeks) _____ ☐Full Term ☐Post-term
Pregnancy complications: ☐None ☐Other: _____
Delivery mode: ☐Vaginal delivery ☐C-Section
Delivery complications: ☐None ☐Other: _____
Birth weight: _____
Hospital stay: ☐Routine newborn care (Home on: ☐Day 2 ☐Day 4 ☐Other ____) ☐Neonatal ICU (How long ____)
☐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: _____
_____

PAST SURGICAL HISTORY:

List significant surgeries or injuries (Write "None" if you have no past surgeries or injuries):

Surgeries/Injuries — *Date(s) or Age/Surgeon*

_____

_____

_____

_____

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:

Please list 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?
☐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) 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

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 Gain	☐	☐
• Recent Weight Loss	☐	☐

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

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	☐	☐

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	☐	☐

(Review of Systems continued)

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 ☐ .. ☐

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 ☐ ... ☐

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

Psychiatric: Yes No
- Depression ☐ .. ☐
- Mood Swings ☐ .. ☐
- Nervousness ☐ .. ☐
- Temper Outburst ☐ .. ☐

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

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

Form Filled Out By:

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

☐Translator: _____

Physician Review: _____ **Date:** _____

☐AMV ☐SGL ☐DML ☐NM