PATIENT NAME: ______________________ DATE: ______________

Date of Birth: ____________ Referring Physician: ______________ Primary Care Physician: ______________

HISTORY – COMPLETED BY PATIENT / PARENT

1. Reason for your visit today ______________________________

2. Please indicate if you (the patient) are currently having problems, signs or symptoms in any of the following areas:

	No	Yes		No	Yes
Fever, weight loss, fatigue, etc.	❑	❑	Neurological	❑	❑
Eyes	❑	❑	Allergies	❑	❑
Ears, Nose, Mouth, Throat	❑	❑	Thyroid / Endocrine	❑	❑
Stomach / Digestion	❑	❑	Psychiatric	❑	❑
Lungs / Breathing	❑	❑	Blood / Lymph	❑	❑
Heart / Circulation	❑	❑	Skin	❑	❑
Muscle / Joints / Bones	❑	❑	Urinary / Reproductive	❑	❑

ROS: 1 Prob. Pertinent, 2-10 Extend, 11> Comprehensive

3. **PAST MEDICAL HISTORY:**

Present Medications: ______________________________

____

Birth weight ______________________________

Date of last dental checkup? ______________________________

Has the patient been diagnosed with a heart murmur?	No	Yes
Any history of being blue or cyanotic?	No	Yes
Any hospitalizations other than for birth?	No	Yes
For what? ______________		
Any serious injuries or illness?	No	Yes
What kind? ______________		
Has the patient had any surgeries?	No	Yes
List surgery ______________		
Has the patient been diagnosed with developmental problems?	No	Yes
Are the patient's immunizations up to date?	Yes	No
Does the patient have asthma?	No	Yes
Is the patient menstruating?	No	Yes
Last menstrual date: ______________		

FEEDING / NUTRITION (Early Life):

Is your child's appetite usually good?	Yes	No
Is it good now?	Yes	No
Any feeding difficulties?	No	Yes
Any excessive sweating?	No	Yes
Any difficulty breathing (hard/fast)?	No	Yes
Current feedings: Breast Milk	Yes	No
Frequency and times ______________		
Formula	Yes	No
What type? ______________		
Amount/Feed? ______________		

GROWTH/DEVELOPMENT:

Do you have any concerns about the patient's growth or development?	No	Yes

4. **HAS THE PATIENT HAD ALLERGIC REACTIONS? NO YES**

5. **FAMILY HISTORY:**

What is the Health Status of the patient's family?

Mother: ____________ Father: ____________ Brother/Sisters: ____________

Are there any close relatives born with heart problems?	No	Yes
Is there a history of sudden death in the family?	No	Yes
Are there any family members with pacemakers?	No	Yes
Is there a history of hypertrophic cardiomyopathy?	No	Yes
Is there a history of long QT Syndrome in the family?	No	Yes
Is there a history of heart disease, heart attack, heart failure?	No	Yes

ACTIVITY:

DOES THE PATIENT...

• have exercise limitations?	No	Yes
• get short of breath with exercise?	No	Yes
• get dizzy with exercise?	No	Yes
• get chest pain with exercise?	No	Yes
• pass out with exercise?	No	Yes
• perform adequate activity for age?	Yes	No

6. **PATIENT'S SOCIAL HISTORY:**

Marital Status: Single Divorced Married Widow/Widower

Current Employer: ______________________________

Who does the patient live with? (Mom, Dad, Sisters, Brothers, Spouse, etc.) ______________

Name of school patient attends and grade ______________

Does the patient smoke? No Yes How many packs per day? ________ For how many years? ________

Does the patient drink alcohol? No Yes How many drinks per day/week/month? ________

Does the patient use illicit drugs? No Yes If yes, what kind? ________

Parent / Legal Guardian Signature ______________________ Date ____________

Physician Signature ______________________ Date ____________