CHILDREN'S HEART CLINIC
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HISTORY QUESTIONNAIRE (AGE 4-21)

Patient Name:_____ Date of Birth:_____

Primary Care Provider:_____

Reason for Visit:_____

List any other provider(s) who should receive records from today's visit:_____

Please mark the column if your child has had other problems or symptoms related to any of the following:			
	Heart murmur		Palpitations or irregular heart beat
	Blueness of any part of the body		Light-headedness
	Difficulty with play or exercise		Dizziness
	Chest pain		Fainting
	Growth difficulty		High blood pressure
	Abnormal weight loss or gain		High cholesterol levels
	Difficulty with bottle feeding or breast feeding		Frequent headache or migraine
	Frequent fever		Shortness of breath
	Frequent sinus or ear infection		Wheezing or asthma
	Frequent throat infection		Seasonal or environmental allergies
	Frequent pneumonia		Chronic cough
	Frequent urinary tract infection		Snoring
	Gastroesophageal reflux		Joint pain or swelling
	Frequent diarrhea or constipation		Swelling of arms, hands, legs or feet
	Abdominal pain		Chronic rash
	Blood in the urine or stool		Unexpected or excessive bleeding or bruising
	Seizures		Abnormal menstruation/periods
	Numbness or tingling		Learning disability
	ADD or ADHD		Developmental disability
	Depression or anxiety		Visual difficulties
	Drug/alcohol substance abuse		Hearing difficulties

Does your child take any medications: ___Yes ___No		
If yes, what medication?	How much?	How often?
1.		
2.		
3.		
4.		
5.		
Is your child allergic to any medications:	**___Yes**	**___No**
If yes, what medication?		
1.		
2.		
Are your child's immunizations up to date:	**___Yes**	**___No**

Health History			
	Yes	No	Comment:
Problems during pregnancy?			
Cesarean Section?			
Problems After Pregnancy?			
Was your child premature?			
Does your child have any chronic health problems?			
Past hospitalizations/ surgical procedures?			

Family History		
Was anyone in your family born with a heart defect?	____Yes_____No	Describe:
Have any family members died suddenly at an early age?	___Yes____No	Describe:
Have any family members required a pacemaker?	___Yes____No	Describe:
Have any family members had early heart attacks? (males <55 yo, females <65yo)	___Yes____No	Describe:
Do you have any of these problems on either side of your family? Check all that apply.		
____Children born with other birth defects ____Children who have had heart surgery ____SIDS or infant death under 1 year of age ____Unexplained death or drowning ____Stroke under 55 years of age ____Pacemaker or defibrillator under 55 years of age ____Death from cardiac cause under 55 years of age ___Death from non-cardiac cause under 55 years of age ___Fainting	____Abnormal/fast/irregular heartbeat or arrhythmia ____High blood pressure ____High cholesterol ____Asthma ____Diabetes, type 1 (requiring insulin) ____Diabetes, type 2 (not requiring insulin) ____Thyroid disease ____Lupus ____Cancer (Please specify:_____) ____Seizures ____Migraine headaches	

_____ _____

Signature **Date**

_____

Print name/ Relationship to patient