CHILDREN'S HEART CLINIC
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HEALTH HISTORY (INFANT-TODDLER)

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 any of the following symptoms:			
	Fast breathing		Swelling of face, hands, or legs
	Difficulty breathing		Cough
	Blueness (cyanosis)		Passing out
	Sweating during feeding		Rapid heart beat
	Shortness of breath during feeding		Difficulty with weight gain or growth
	Unusual shortness of breath with exertion		

Please mark the column if your child has had any of the following:			
	Headaches		Seizures
	Eyes		Developmental delay
	Ear, Nose, Throat		Skin
	Feeding		Bleeding
	Chronic diarrhea or constipation		Bruising
	Kidney or bladder		Allergies
	Muscles		Diabetes
	Bones		Mental Health

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 mediations:	**___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?			
Child's birth weight			
Was your child premature?			
Does your child have any chronic health problems?			
Past hospitalizations?			
Past Surgical Procedures?			
Is your child fed through a tube?			
What does your child eat?	___Breast milk___Bottle milk ___Regular foods		

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	___Abnormal/fast/irregular heartbeat or arrhythmia
___Children who have had heart surgery	___High blood pressure
___SIDS or infant death under 1 year of age	___High cholesterol
___Unexplained death or drowning	___Asthma
___Stroke under 55 years of age	___Diabetes, type 1 (requiring insulin)
___Pacemaker or defibrillator under 55 years of age	___Diabetes, type 2 (not requiring insulin)
___Death from cardiac cause under 55 years of age	___Thyroid disease
___Death from non-cardiac cause under 55 years of age	___Lupus
___Fainting	___Cancer (Please specify:_____)
	___Seizures
	___Migraine headaches

Signature **Date**

Print name/ Relationship to patient