

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:

	<u>No</u>	<u>Yes</u>		<u>No</u>	<u>Yes</u>
Fever, weight loss, fatigue, etc.	<input type="checkbox"/>	<input type="checkbox"/>	Neurological	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Ears, Nose, Mouth, Throat	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid / Endocrine	<input type="checkbox"/>	<input type="checkbox"/>
Stomach / Digestion	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Lungs / Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Blood / Lymph	<input type="checkbox"/>	<input type="checkbox"/>
Heart / Circulation	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>
Muscle / Joints / Bones	<input type="checkbox"/>	<input type="checkbox"/>	Urinary / Reproductive	<input type="checkbox"/>	<input type="checkbox"/>

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 No Yes

the patient's growth or development?

4. **HAS THE PATIENT HAD ALLERGIC REACTIONS?** 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

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

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 _____

NAME: _____ DOB: _____ AGE: _____ ROOM #: _____

HPI: _____ Referring Physician: _____

HPI
1-3 99241/99242
>4 99243/99244/99245

BP _____ HR _____ Resp. Rate _____ Oximetry _____ % Ht _____ (_____ %) Weight _____ (_____ %)
Appearance: well developed, well nourished, obese, thin, cachetic

Head and Face: Normal _____
Eyes: Conjunctivae and lids Normal _____
Ears/Nose/Mouth/Throat:
Teeth, gums, palate Normal _____
Oral mucosa Normal _____
Neck: Jugular veins(distension) Normal _____
Thyromegaly Absent _____

ALLERGIES: _____

MEDICATIONS: _____

Respiratory

Respiratory Effort/Palpation
Auscultation/breath sounds

Gastrointestinal

Abd for Tenderness/Masses
Hepatosplenomegaly
Bowel Sounds

Neuro/Psych: Brief assessment mental status
orientation to time, place and person
Mood/affect (depression, anxiety, agitation)

Cardiovascular

Palpitation of heart (size, PMI)
Auscultate – murmurs, rubs, clicks
Regular rate & rhythm
Abd. Aorta (bruits)
Carotid arteries (bruits)
Femoral pulses
Pedal pulses
Extremity edema
B/P in 2 or more for coarctation

Chest (Breasts) Normal _____

Musc: Clubbing _____

Exam of gait & station Normal _____

Inspection digits, nails Normal _____

Assessment of strength Normal _____

Integ: Acyanotic, Cyanotic Normal _____

Rashes/papular/vesicular

Lesions, ulcers, erythema

Irregular margins

Induration, nodules

Hematologic/Lymphatic Normal _____

ASSESSMENT:

Holter Stress Test EKG M-Mode/2D Color Doppler Doppler PW/CW

Indication: _____

Test Next Visit: _____

SBE Card Provided: _____ YES _____ NO

Exercise Restrictions: _____ YES _____ NO _____ TYPE

Hand Out Given: _____

PLAN:

Physician Signature _____ Date _____

ORL ALT PB DAY RCK TV