

NORTHWEST CENTER FOR CONGENITAL HEART DISEASE

*New Patient Questionnaire – Adolescent
(Please fill out/check boxes as best as you can)*

Patient's Name: _____ Date of Appointment: _____

Birth Date: _____ Age: _____ Sex: Male Female

Primary Care Provider (PCP): _____

Referring Provider (if different from PCP): _____

Reason for Cardiology Visit: _____

Birth History: Newborn Problems: Cardiac problems, Respiratory problems, Jaundice, Infection, Prematurity, Feeding problems, Other _____

Past Medical History: (Check and explain briefly only if the following have been problems)

- ADD/ADHD/Behavior problems: _____
- Asthma: _____
- Chromosome/Genetic problems: _____
- Frequent ear/sinus/throat infections: _____
- Pneumonia/respiratory infections: _____
- GE Reflux: _____
- Seizures: _____
- Other: _____
- Hospitalizations (explain non cardiac hospital admissions): _____

Past Surgical History: (please list non cardiac surgeries, date, and Doctor)

Family History: Please check and explain for immediate family members (parents, siblings, grandparents, aunts/uncles)

- Congenital Heart Disease (born with abnormal heart) _____
- Sudden Unexpected Death _____
- Genetic Disorder _____
- Early Coronary Disease (under 50 years) _____
- Heart Rhythm Disturbance _____
- High Cholesterol _____
- Other _____
- Child is adopted _____

Social History: (please check only what applies)

Child lives with Both parents Mother Father Other: _____

Parents are: Married Divorced Separated Both parents involved Child in Foster care

List household members: _____

School: Child attends Grade Level: _____ Name of School: _____

Type of student: Average Above average Below average

Social Stressors: Recent move, Divorce, Grades, School bullies, Other: _____

Sports: _____

Activities or Hobbies: _____

Smoking or other Tobacco use: _____

Alcohol use: _____

Recreational Drug Use: _____

Sexually Active: _____

Immunizations: Up to date Behind Not sure

Patient Information Sheet (Pediatric)

Patient's Name: _____ SS#: _____
first middle initial last
Birthdate: _____ **Age:** _____ **SEX:** Male Female

Parent/Guardian's Name: _____ D.O.B. _____ SS#: _____
Address: _____

City State Zip code **Home Phone:** () _____
Employer: _____ **Occupation:** _____
Work No: () _____ **Cell No:** () _____

Other Parent Name: _____ D.O.B. _____ SS#: _____
Address: _____

City State Zip code **Home Phone:** () _____
Employer: _____ **Occupation:** _____
Work No: () _____ **Cell No:** () _____

Pharmacy: Name: _____ **Phone:** () _____
Location: _____

Patient's Primary Care Physician: _____ **Phone:** () _____
Patient's Referring Physician: _____ **Phone:** () _____
Emergency Contact: _____ **Relationship:** _____ **Phone:** () _____

Insurance (Primary)

Subscribers Name: _____
Insured D.O.B _____
Policy No: _____ Group# _____
Insurance Name: _____
Address: _____

Insurance (Secondary)

Subscribers Name: _____
Insured D.O.B _____
Policy No: _____ Group# _____
Insurance Name: _____
Address: _____

I authorize payment of Medical Benefits to Physician:

Signature of Parent/Guardian: _____ **Date:** _____