

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)

List household members and their ages: (Example: Mother 34, Father 35, Brother 10, Sister 12, etc) _____

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

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

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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:** _____