KNOXVILLE PEDIATRIC CARDIOLOGY
PATIENT HISTORY

PATIENT NAME: _____

DATE OF BIRTH: ____/____/____ **REFERRING PHYSICIAN:** _____

Please describe why your Physician referred you/your child to our practice: _____

_____

_____

Please list all person living in the home with the patient: _____

_____

Smoking? : _____

Please circle any of the following conditions the patient has experienced: (now or in the past)

Rapid/Difficult Breathing:	YES	NO	Colic:	YES	NO
Coughing/Wheezing:	YES	NO	Kidney Disease:	YES	NO
Pneumonia:	YES	NO	Blood in Urine:	YES	NO
Swollen Joints:	YES	NO	Convulsions/Seizures:	YES	NO
Excessive Sweating:	YES	NO	Bad Teeth:	YES	NO
Excessive irritability:	YES	NO	Nose Bleeds:	YES	NO
Easy Tiring with Exercise:	YES	NO	Headaches/Migraines:	YES	NO
Fainting/Passing out spells:	YES	NO	Kawasaki's Disease:	YES	NO
Rheumatic Fever:	YES	NO	Abnormal Heart Rate/Rhythm:	YES	NO
Swelling of Face, Hands, or Feet:	YES	NO			

Child Birth/Development (Complete for children 5 and under)

Hospital/City : _____ **Length of stay in hospital:** _____

Was your child born prematurely? YES NO
How many weeks pregnant was mom at time of delivery? _____
Birth Weight: _____

Approximate age your child did each of the following:

Rolled Over: _____ **Sat Alone** _____

Walked Alone: _____ **Speech Development:** _____

Learning Performance: **Fast** **Normal** **Slow**

Biological Family History

Mother

Name:_____

Age:_____

Occupation:_____

Tobacco Use:_____

Serious Illnesses:_____

Pregnancies:_____

Premature Births:_____

Term Births:_____

Miscarriages:_____

Father

Name:_____

Age:_____

Occupation:_____

Tobacco Use:_____

Serious Illnesses:_____

PARENTS: (Please circle below)

Married Divorced Never Married

**Any children born with heart disease, heart defects, or other birth defects? YES NO

Please describe:_____

Brothers and Sisters of the patient

Name	Age	Sex	Condition of Health	Serious Illnesses

Please check all Medical Conditions that any one either side of the Family has or has had.

_____Sudden Death (Early Age)
_____Coronary Artery or Blood Vessel Disease
_____Heart Attack (Male <50 Female <60)
_____Heart Murmur
_____Heart Failure
_____High Blood Pressure
_____High Cholesterol
_____Heart transplants
_____Mental Retardation
_____Cardiomyopathy
_____Implanted defibrillator
_____Diabetes

_____Deafness
_____Fainting or Passing Out
_____Muscle disease/dystrophy
_____Rheumatic Fever
_____Arthritis
_____Kidney Disease
_____Liver Disease
_____Convulsions or Seizure Disorders
_____Stroke
_____Cancer or Leukemia
_____Blood Disorders
_____Thyroid Disease

Please describe any other Family Medical History not listed:

_____

_____