

New Patient Questionnaire

DUKE CHILDREN'S CARDIOLOGY OF RALEIGH AND CARY

Angelo Milazzo, MD, FAAP, FACC
Salim Idriss, MD, PhD, FAAP, FACC
Cathy Robinson, RN

Parent(s)/guardian(s):

Name: _____ Name: _____

Home phone: _____ Home phone: _____

Work phone: _____ Work phone: _____

Cell phone: _____ Cell phone: _____

E-mail: _____ E-mail: _____

Please list the names of any other adults whom we may contact or with whom we may share information:

Name: _____ Relationship to patient: _____ Telephone: _____

Who referred you for today's visit? _____

Pediatrician or primary care provider: _____

Name of practice: _____

Location of practice: _____

What is the reason for today's visit? _____

Has the patient been evaluated by a pediatric cardiologist before? Yes No

Does the patient see any other pediatric specialists? Yes No

If "yes," please list them: _____

Is the patient in daycare? Yes No N/A

If the patient is in school, what grade? _____

Does the patient exercise regularly? Yes No N/A

If the patient plays organized sports, please list them: _____

Were there any difficulties with the patient's birth? Yes No

Are the patient's immunizations up-to-date? Yes No

Please see additional questions on the reverse of this form

New Patient Questionnaire

DUKE CHILDREN'S CARDIOLOGY OF RALEIGH AND CARY

Angelo Milazzo, MD, FAAP, FACC
Salim Idriss, MD, PhD, FAAP, FACC
Cathy Robinson, RN

Does the patient have any of the following symptoms or problems? Check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Palpitations or irregular heartbeat |
| <input type="checkbox"/> Blueness of any part of the body | <input type="checkbox"/> Light-headedness |
| <input type="checkbox"/> Difficulty with play or exercise | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Growth difficulty | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Abnormal weight loss or gain | <input type="checkbox"/> High cholesterol levels |
| <input type="checkbox"/> Difficulty with bottle feeding or breast feeding | <input type="checkbox"/> Frequent headache or migraine |
| <input type="checkbox"/> Frequent fever | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Frequent sinus or ear infection | <input type="checkbox"/> Wheezing or asthma |
| <input type="checkbox"/> Frequent throat infection | <input type="checkbox"/> Seasonal or environmental allergies |
| <input type="checkbox"/> Frequent pneumonia | <input type="checkbox"/> Chronic cough |
| <input type="checkbox"/> Frequent urinary tract infection | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Gastroesophageal reflux (GERD) | <input type="checkbox"/> Joint pain or swelling |
| <input type="checkbox"/> Frequent diarrhea or constipation | <input type="checkbox"/> Swelling of arms, hands, legs or feet |
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Chronic rash |
| <input type="checkbox"/> Blood in the urine or stool | <input type="checkbox"/> Unexpected or excessive bleeding or bruising |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Learning disability |
| <input type="checkbox"/> Numbness or tingling | <input type="checkbox"/> Developmental disability |
| <input type="checkbox"/> ADD or ADHD | <input type="checkbox"/> Visual difficulties |
| <input type="checkbox"/> Depression or anxiety | <input type="checkbox"/> Hearing difficulties |

Has the patient had surgery? Yes No

If "yes," please explain: _____

Has the patient been hospitalized? Yes No

If "yes," please explain: _____

Do you have any of these problems on either side of your family? Check all that apply.

- | | |
|---|---|
| <input type="checkbox"/> Children born with heart defects | <input type="checkbox"/> Arrhythmia or irregular heart beat |
| <input type="checkbox"/> Children born with other birth defects | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> SIDS or infant death under 1 year of age | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Heart attack under 55 years of age | <input type="checkbox"/> Diabetes, type 1 (requiring insulin) |
| <input type="checkbox"/> Stroke under 55 years of age | <input type="checkbox"/> Diabetes, type 2 (not requiring insulin) |
| <input type="checkbox"/> Placement of a pacemaker under 55 years of age | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Death from a cardiac cause under 55 years of age | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Death from a non-cardiac cause under 55 years of age | <input type="checkbox"/> Cancer |

Signature of parent, guardian or patient (if 18 years or older)

Date

Printed name

Thank you for completing this questionnaire