

# New Patient Questionnaire

DUKE CHILDREN'S CARDIOLOGY OF RALEIGH  
Angelo Milazzo, MD  
Salim Idriss, MD, PhD, FAAP, FACC  
Cathy Robinson, RN

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_

Primary address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent(s)/guardian(s):

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Home phone: \_\_\_\_\_ Home phone: \_\_\_\_\_

Work phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Cell phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

E-mail: \_\_\_\_\_ E-mail: \_\_\_\_\_

Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Name:	Relationship to patient:	Telephone:
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_____	_____	_____
_____	_____	_____

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/preschool/school?  Yes  No  N/A

If the patient is in school, what grade? \_\_\_\_\_

Does the patient exercise regularly?  Yes  No  N/A

Please list organized sports or other activities: \_\_\_\_\_

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

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

Do you have any pets?  Yes  No

Please see additional questions on the reverse of this form

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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                                     |
| <br>  |   |
| <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                |
| <br>  |   |
| <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                                      |
| <br>  |   |
| <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 |
| <br>  |   |
| <input type="checkbox"/> Seizures   | <input type="checkbox"/> Abnormal menstruation/periods                |
| <input type="checkbox"/> Numbness or tingling                             | <input type="checkbox"/> Learning disability                          |
| <input type="checkbox"/> ADD or ADHD                                      | <input type="checkbox"/> Developmental disability                     |
| <input type="checkbox"/> Depression or anxiety                            | <input type="checkbox"/> Visual difficulties                          |
|   | <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"/> Abnormal/fast/irregular heartbeat or arrhythmia |
| <input type="checkbox"/> Children born with other birth defects               | <input type="checkbox"/> High blood pressure                             |
| <input type="checkbox"/> Children who have had heart surgery                  | <input type="checkbox"/> High cholesterol                                |
| <input type="checkbox"/> SIDS or infant death under 1 year of age             | <input type="checkbox"/> Asthma  |
| <input type="checkbox"/> Unexplained death or drowning                        | <input type="checkbox"/> Diabetes, type 1 (requiring insulin)            |
| <input type="checkbox"/> Heart attack under 55 years of age                   | <input type="checkbox"/> Diabetes, type 2 (not requiring insulin)        |
| <input type="checkbox"/> Stroke under 55 years of age                         | <input type="checkbox"/> Thyroid disease                                 |
| <input type="checkbox"/> Pacemaker or defibrillator under 55 years of age     | <input type="checkbox"/> Lupus   |
| <input type="checkbox"/> Death from a cardiac cause under 55 years of age     | <input type="checkbox"/> Cancer (Please specify: _____)                  |
| <input type="checkbox"/> Death from a non-cardiac cause under 55 years of age | <input type="checkbox"/> Seizures  |
| <input type="checkbox"/> Fainting   | <input type="checkbox"/> Migraine headaches                              |

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name

Thank you for completing this questionnaire