Children's Heart Center of Central Oregon

PREVENTIVE CLINIC PATIENT QUESTIONNAIRE

Please answer the following questions regarding the patient/child to be seen, if applicable:

Today's Date: _____
Patient's Name: _____
Age: _____

Guardian/Custodial Party(s):_____
Relationship to Patient:
☐ Mother ☐ Father ☐ Grandparent ☐ Other _____
☐ Stepmother ☐ Stepfather ☐ Foster parent(s)

What is the reason for your visit to The Pediatric Heart Center?

_____

_____

Does the patient experience any of the following:

	NO	YES		NO	YES
Abnormal weight gain	☐	☐	Snoring	☐	☐
Difficulty breathing	☐	☐	Irregular breathing during sleep	☐	☐
Exercise intolerance	☐	☐	Disrupted sleep or insomnia	☐	☐
Abnormal thirst	☐	☐	Sleepwalking	☐	☐
Frequent urination	☐	☐	Attention deficit or hyperactivity	☐	☐
			Sleepiness during day	☐	☐
Headaches	☐	☐	Irregular menstrual periods	☐	☐
Vomiting	☐	☐	Severe acne	☐	☐
Vision abnormalities	☐	☐	Hair loss	☐	☐
Skin changes	☐	☐	Abnormal hair growth	☐	☐

Do you have concerns about the patient's growth or development ? ☐ No ☐ Yes
If so, state concerns:

_____

_____

_____

MEDICAL HISTORY:
Birth weight: _____lbs _____oz
Was the patient born premature? ☐ No ☐ Yes If so, how many weeks?_____

Were there any pregnancy complications? ☐ No ☐ Yes ☐ Don't know
If yes, please describe:_____

Were there any problems during delivery or in the nursery? ☐ No ☐ Yes ☐ Don't know
If yes, please describe: _____

Has the patient been hospitalized (please include surgical procedures)? ☐ No ☐ Yes ☐ Don't know
If yes, please explain (diagnosis, when, where):
_____
_____

Please list current medications and doses. Please include any over the counter medications, dietary supplements, prescription medications, and reasons for taking:

_____

_____

_____

Allergies: ☐ None
☐ Drug allergies: _____
☐ Other allergies: _____

Are the patient's immunizations up to date? ☐ Yes
☐ No Please explain: _____
☐ Don't know

Please check if the patient has ever had the following:
☐ EKG ☐ Exercise test (stress test) ☐ Echocardiogram

FAMILY HISTORY:
Please list child's siblings, their ages, and any health problems:
_____ _____
_____ _____
_____ _____

Have any family members (including aunts, uncles, cousins, grandparents) had:
☐ Born with heart defect ☐ Heart rhythm abnormality ☐ Sudden death at a young age ☐ Asthma

Please check if the patient's relatives have had a myocardial infarction (heart attack) before age 55 (male relatives) or before age 65 (female relatives):

_____Father _____Paternal grandfather _____Paternal uncle _____Paternal aunt
_____Mother _____Maternal grandfather _____Maternal uncle _____Maternal aunt
_____Sibling _____Cousin

Please check if the patient's relatives have had the following at any age:

	High blood pressure	Diabetes	Obesity	High cholesterol	Stroke before age 55	Sleep apnea	Kidney disease
Father							
Mother							
Paternal grandfather							
Paternal grandmother							
Paternal uncle							
Paternal aunt							
Maternal grandfather							
Maternal grandmother							
Maternal uncle							
Maternal aunt							
Sibling							
Cousin							

SOCIAL HISTORY:

Patient's grade in school: _____ Name of school: _____ ☐ Home schooled

Who lives with patient? ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather

☐ Other: _____

Please list **occupations** of parent(s)/guardian(s):

Father _____ Mother _____

Stepfather _____ Stepmother _____

Other, if applicable: _____

Are there any pets at home (list)? _____

Is the patient active in sports? ☐ No ☐ Yes If yes, which ones?

_____

Do any persons living at home use tobacco (smoke cigarettes or cigars)?
☐ No (skip the next question)
☐ Yes

Who uses tobacco (smokes cigarettes or cigars)? Check all that apply.
☐ Patient ☐ Stepfather ☐ Grandparent
☐ Father ☐ Stepmother ☐ Sibling
☐ Mother ☐ Other

On average, how many hours per day does the patient spend watching television?
☐ one hour or less ☐ two to four hours
☐ one to two hours ☐ more than four hours

On average, how many hours per day does the patient spend using a computer or playing video games?
☐ one hour or less ☐ two to four hours
☐ one to two hours ☐ more than four hours

On average, how many hours per day does the patient spend doing **VIGOROUS** physical activity?
☐ one hour or less ☐ two to four hours
☐ one to two hours ☐ more than four hours

In your opinion, how healthy are your eating habits?
☐ Very healthy ☐ Average ☐ Poor

Have you participated in any diets or dietary programs? ☐ No ☐ Yes

How many televisions do you have at home? _____

Who does most of the cooking at home? _____

Who does most of the grocery shopping? _____

How many days a week do you eat out? _____

Does the patient…	**NO**	**YES**
drink alcohol ?.....	☐	☐
use drugs not prescribed by a physician ?.....	☐	☐
smoke/use tobacco?	☐	☐
use caffeine (coffee, tea, soda, energy drinks, pills)?	☐	☐

REVIEW OF SYSTEMS:

Has the patient experienced any of the following **IN THE PAST MONTH:**
(please explain any checked boxes below)

General:	**None:** ☐	☐ Fatigue ☐ Weakness	☐ Weight loss	☐ Weight gain	☐ Fever
Skin:	☐	☐ Rash	☐ Color change		
Eyes:	☐	☐ Glasses	☐ Other vision problems		
ENT:	☐	☐ Ear infections ☐ Hoarseness	☐ Sinus infection ☐ Bleeding gums	☐ Hearing problems ☐ Cavities or other dental problems	☐ Nasal discharge ☐ Orthodontics
Sleep:	☐	☐ Snoring	☐ Daytime sleepiness	☐ Irregular breathing during sleep	☐ Difficulty sleeping
Lungs:	☐	☐ Shortness of breath ☐ Other breathing difficulties	☐ Cough ☐ Wheezing	☐ Pneumonia ☐ Noisy breathing	☐ Asthma ☐ Coughing blood
Gastrointestinal:	☐	☐ Nausea ☐ Vomiting ☐ Constipation	☐ Abdominal swelling ☐ Bloody stools	☐ Diarrhea ☐ Black stools	☐ Abdominal pain ☐ Jaundice
Genitourinary:	☐	☐ Frequent urination	☐ Blood in urine	☐ Painful urination	
Menstrual:	☐	☐ First day of last period _____	☐ Irregularity	☐ Pain/cramping	
Musculoskeletal:	☐	☐ Scoliosis ☐ Joint pain	☐ Other spine problems	☐ Joint swelling	☐ Joint redness
Endocrine:	☐	☐ Heat/ cold intolerance	☐ Change in appetite	☐ Excessive thirst	
Hematologic:	☐	☐ Anemia ☐ Swollen glands	☐ Bruising	☐ Bleeding	☐ Blood clots
Neurologic:	☐	☐ Seizures ☐ Dizziness ☐ Paralysis	☐ Headaches ☐ Poor coordination ☐ Weakness	☐ Numbness ☐ Difficulty walking	☐ Tingling ☐ Difficulty speaking
Psychologic:	☐	☐ Depression ☐ Nightmares	☐ Anxiety ☐ Mood change	☐ Drug/ alcohol abuse ☐ Attention deficit	☐ Phobias ☐ Hyperactivity

Other concerns:

_____

_____

_____