Children's Heart Center of Central Oregon
Patient Questionnaire

Patient's Name: _____ Today's Date: _____
Name patient likes to be called, if different from above: _____ Age:_____
Who is with the patient at today's visit?

- ☐ Mother
- ☐ Father
- ☐ Stepmother
- ☐ Stepfather
- ☐ Grandparent
- ☐ Aunt/uncle
- ☐ Foster parent
- ☐ Friend
- ☐ Other _____

What is the main question or concern that we can help you with today?

_____

Which of the following symptoms are experienced by the patient?

Babies/toddlers only:

- ☐ Poor feeding
- ☐ Sweating with feeds
- ☐ Poor weight gain
- ☐ Unusual irritability

Development (all patients):
Do you have concerns about the following:

- ☐ Motor or language skills
- ☐ Social or emotional development
- ☐ Learning/academic skills
- ☐ Behavior

All patients, including babies/toddlers:

- ☐ Turning blue
- ☐ Breathing difficulty
- ☐ Trouble with exercise/activity
- ☐ Abnormal fatigue
- ☐ Fainting
- ☐ Chest pain
- ☐ Palpitations (fast or abnormal heartbeats)
- ☐ Dizziness/lightheadedness

☐ **No symptoms at all**

PREGNANCY/MEDICAL HISTORY

☐ I don't know details about the pregnancy or delivery. (If you don't know, please continue to **hospitalizations** below.)

Patient was born ☐ on time ☐ prematurely (if so, how many weeks premature? _____)
Birth weight: _____lbs_____oz
Pregnancy complications (check all that apply, and give any applicable details in space provided):

- ☐ Maternal illness _____
- ☐ Maternal tobacco use _____
- ☐ Maternal drug use _____
- ☐ Maternal alcohol use _____
- ☐ Medications other than prenatal vitamins _____
- ☐ Other complications _____

Was a fetal echocardiogram performed during the pregnancy? ☐ No ☐ Yes
Were there any problems during delivery? ☐ No ☐ Yes (please explain below:)

_____
_____

Newborn complications (check all that apply, and give any applicable details in space provided):

- ☐ Baby needed oxygen (how long _____) _____
- ☐ Baby was on ventilator (how long _____) _____
- ☐ Diagnosis of genetic syndrome _____
- ☐ Diagnosis of heart defect _____
- ☐ Other newborn complications _____

Hospitalizations. Not including emergency room or urgent care visits, has the patient been hospitalized? ☐ No ☐ Yes
If yes, please provide details (please include surgical procedures):

When?	Where?	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list current medications and reasons for taking:

Medication	Reason	Medication	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies: □ None
□ Drug allergies _____
□ Other allergies _____

Are patient's immunizations up to date?
☐ Yes
☐ No; reason: □ Catching up □ Religious □ Parent choice □ Other

FAMILY HISTORY

Check all that apply (parents, siblings, aunts, uncles, cousins, or grandparents), and provide details in space provided:

What:	*Who/any other details:*
☐ Born with heart defect	_____
☐ Heart rhythm abnormality	_____
☐ Sudden death at young age	_____
☐ Fainting	_____
☐ Heart murmur	_____
☐ High cholesterol	_____
☐ Early heart attack	_____
☐ Hypertension	_____
☐ Asthma	_____
☐ Other	_____

SOCIAL HISTORY

Who does patient live with (check all that apply)?

☐ Biological mother ☐ Adoptive parent(s) ☐ Aunt/uncle
☐ Biological father ☐ Stepmother ☐ Foster parent
☐ Sibling(s); how many _____ ☐ Stepfather ☐ Friend
☐ Shared custody ☐ Grandparent ☐ Other _____

Does anyone at home use tobacco? □ No □ Yes

Please list occupations of patient's primary caregivers:

Mom_____ Other_____
Dad_____ Other_____

School (check all that apply):

☐ Not in school yet ☐ Preschool/prekindergarten
☐ Grade K-12 ⇒ Which grade_____ Name of school: _____
☐ Home school (grade level _____) ☐ Online school
☐ Currently not in school ☐ Has GED
☐ Graduated from high school
☐ College ⇒ Major_____ Name of school: _____

Physical activity: Is patient active in sports (check all that apply)?

☐ Not active at all
☐ Active play (young children)
☐ Recreational sports (friends, parks and rec, etc.)(which sports_____)
☐ Competitive sports through school (which ones _____)
☐ Competitive club sports (which ones _____)
☐ Individual sports/workouts (what type _____)
☐ Other_____

Does patient keep up well with peers? □ Yes □ No

Does patient use any of the following:

☐ Tobacco ☐ Energy drinks
☐ Recreational drugs ☐ Other caffeine (pop/tea/coffee/pills)
☐ Alcohol ☐ Exposed to second hand tobacco at home

REVIEW OF SYSTEMS

Is the patient experiencing any of the following symptoms or problems? Please check all that apply, and explain in comment section below.

	NONE ☐				
GENERAL		☐ weakness	☐ fever	☐ weight loss	☐ weight gain
SKIN	☐	☐ rash	☐ color change		
EYES	☐	☐ wears glasses	☐ other vision problems (please explain)		
EARS/NOSE/THROAT	☐	☐ ear infections ☐ hearing problems ☐ bleeding gums	☐ sinus infections ☐ nasal discharge ☐ bloody noses	☐ wears orthodontics ☐ bleeding gums ☐ cavities/other dental issues; please explain	
SLEEP	☐	☐ snoring	☐ irregular breathing during sleep	☐ difficulty sleeping	☐ daytime sleepiness
LUNGS	☐	☐ cough	☐ wheezing	☐ noisy breathing	☐ coughing up blood
GASTROINTESTINAL	☐	☐ nausea ☐ vomiting	☐ constipation ☐ diarrhea	☐ abdominal pain ☐ abdominal swelling	☐ bloody stools
URINARY	☐	☐ blood in urine	☐ painful urination	☐ frequent urination	
MENSTRUAL (females only)	☐	☐ menstrual irregularity	☐ menstrual cramping		
MUSCULOSKELETAL	☐	☐ scoliosis ☐ back pain	☐ joint swelling	☐ joint pain; please explain	
ENDOCRINE	☐	☐ excessive thirst	☐ heat/cold intolerance	☐ change in appetite; please explain	
HEMATOLOGIC	☐	☐ anemia	☐ easy bruising	☐ abnormal bleeding	☐ blood clots
NEUROLOGIC	☐	☐ seizures ☐ headaches	☐ poor coordination ☐ numbness	☐ difficulty walking ☐ difficulty speaking	☐ tingling
PSYCHOLOGIC	☐	☐ depression ☐ anxiety	☐ mood changes	☐ attention deficit ☐ hyperactivity	☐ unusual stress

Comments or other concerns:

_____

_____

_____

_____

_____