# Presbyterian Pediatric Cardiology History

NOVANT HEALTH

Patient Name: _____ Patient Date of Birth: _____

List Previous Hospitalizations: _____

**Please indicate by checking the box if the patient has been experiencing any of the following symptoms:**

- ☐ Chest pain
- ☐ Palpitations (heart racing or skipping beats)
- ☐ Weakness or dizziness
- ☐ Fever
- ☐ Unexplained Weight loss or gain
- ☐ Rash or skin lesions
- ☐ Eye drainage
- ☐ Nasal congestion
- ☐ Ear drainage
- ☐ Cough, Wheezing or Difficulty breathing
- ☐ Blue discoloration of the skin
- ☐ Pallor (pale appearance to the skin)
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Seizures
- ☐ Bruising

**Immediate Family History-(Mom, Dad, Siblings): Please indicate if any of the following:**

- ☐ Birth Defects
- ☐ Congenital hearing loss
- ☐ Abnormalities of heart valves
- ☐ Hypertrophic cardiomyopathy
- ☐ Enlarged heart
- ☐ Long QT syndrome
- ☐ High cholesterol
- ☐ Fainting
- ☐ Sudden unexplained death
- ☐ Hypertension
- ☐ Seizures
- ☐ Diabetes

**Birth History: (if patient is under 5 years of age):**

Birth weight: _____

How many weeks gestation at time of delivery (term/preterm)? _____

Type of delivery: ☐ Vaginal ☐ C-Section

Hospitalization in the NICU ? ☐ Yes ☐ No

**Other**

Grade in school: _____

Does the patient participate in competitive sports? ☐ Yes ☐ No

Who lives at home? _____

Completed by: _____ Date: _____ Time: _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost::

☐ Interpreter Accepted _____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

NOVANT HEALTH **Not Part of Medical Record**

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