

New Patient Questionnaire

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

Patient's Name _____ DOB _____

Parent(s)/guardian(s):

Name: _____ Name: _____

Primary address: _____

City: _____ State: _____ Zip: _____

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

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

- Heart murmur
- Palpitations or irregular heartbeat
- Blueness of any part of the body
- Light-headedness
- Difficulty with play or exercise
- Dizziness
- Chest pain
- Fainting

- Growth difficulty
- High blood pressure
- Abnormal weight loss or gain
- High cholesterol levels
- Difficulty with bottle feeding or breast feeding
- Frequent headache or migraine

- Frequent fever
- Shortness of breath
- Frequent sinus or ear infection
- Wheezing or asthma
- Frequent throat infection
- Seasonal or environmental allergies
- Frequent pneumonia
- Chronic cough
- Frequent urinary tract infection
- Snoring

- Gastroesophageal reflux (GERD)
- Joint pain or swelling
- Frequent diarrhea or constipation
- Swelling of arms, hands, legs or feet
- Abdominal pain
- Chronic rash
- Blood in the urine or stool
- Unexpected or excessive bleeding or bruising

- Seizures
- Learning disability
- Numbness or tingling
- Developmental disability
- ADD or ADHD
- Visual difficulties
- Depression or anxiety
- 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.

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

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

Date

Printed name

Thank you for completing this questionnaire