SIBLEY HEART CENTER CARDIOLOGY
INTERVAL HISTORY - 1

Patient Name: _____ Date of Birth: _____

Name and Relation of Person Completing this Form: _____

Reason for this visit: ☐ Routine Follow-up ☐ New Problem
Explain: _____

Primary Care Physician: _____

Tell me about any changes since your last visit: _____
_____
_____

OFFICE NOTES (HPI): Referred by Dr. _____ **to evaluate** _____
_____
_____
_____
_____
_____
_____
_____
_____

RECENT HOSPITALIZATIONS, SURGERIES, MAJOR ILLNESSES: ☐ **NONE (since last visit)**

Problem:	Age/Date	Problem:	Age/Date

REVIEW OF SYSTEMS: (Please check Normal or Abnormal)

☐ **Discussed with family**

	Normal	**Abnormal**	**Physician Notes: (Comment on abnormality)**
Weight Change or Poor Appetite	_____	_____	_____
Eyes	_____	_____	_____
Ears, Nose and Throat	_____	_____	_____
Lungs and Breathing	_____	_____	_____
Heart and Circulation	_____	_____	_____
Stomach and Digestion	_____	_____	_____
Kidneys and Bladder	_____	_____	_____
Hormones and Glands	_____	_____	_____
Blood and Lymph System	_____	_____	_____
Bones and Joints	_____	_____	_____
Nervous System	_____	_____	_____
Emotional or Behavioral Issues	_____	_____	_____
Skin and/or Allergies	_____	_____	_____

Last Name: _____

Nurse Signature: _____ **First Name:** _____

Physician Signature: _____ **Patient #:** _____

Date of Visit: _____ **DOB:** _____

Revised 2/07

SIBLEY HEART CENTER CARDIOLOGY
INTERVAL HISTORY - 2

CHECK ALL THAT APPLY TO PATIENT:

Exercise: None _____Occasionally _____Daily _____Athlete: Competitive _____Recreational _____

Diet: Usual American _____ Low Fat _____ Low Salt _____ Vegetarian _____Other _____

Feeding:

Breast ☐ Yes ☐ No ☐ N/A

Formula ☐ Yes ☐ No ☐ N/A Brand Name _____No. Ounces/feed _____Frequency_____

Feeding Notes: _____

Smoking: ☐ N/A No. Packs/day _____ How Long _____years

Alcohol : ☐ N/A Type _____ Amount _____day/week/month

Sexual Activity: ☐ Yes ☐ No ☐ N/A Currently Pregnant ☐ Yes ☐ No LMP Date _____ ☐ N/A

Birth Control: ☐ Yes ☐ No Type_____

FAMILY HISTORY NOTES: (Any new information about family members since last visit): ☐ N/C (no changes)

_____

_____

_____

_____

_____

SOCIAL HISTORY: (Changes since last visit): ☐ N/C (no changes)

Parents:

Mother: _____

Father: _____

Brothers: _____

Sisters: _____

Patient School Grade: _____

ALLERGIES: ☐ NONE

_____

_____

IMMUNIZATIONS: ☐ NONE Up To Date: ☐ Yes ☐ No Age last Immunization _____ ☐ Synagis

MEDICATIONS: ☐ NONE (List all being taken **NOW**) **Reviewed:** _____

Drug Name	Concentration	Amount	Frequency

Does patient take Antibiotics Prior to Dental procedures or Operations: (SBE)? ☐ Yes ☐ No

PHYSICIAN/NURSE NOTES:

_____

_____

_____

_____

Nurse Signature: _____ **Patient Name:** _____

Physician Signature: _____ **Patient #:** _____

Date of Visit: _____ **DOB:** _____

Patient #: _____ **PATIENT RECORD** Date: _____

PLEASE PRINT **SIBLEY HEART CENTER CARDIOLOGY**

Patient Last Name: _____ First _____ MI _____

Patient Social Security: _____ Sex: ____ Date of Birth: _____

Address: _____

City: _____ State _____ Zip _____ County _____

Home Phone: _____ Work Phone: _____

GUARANTOR'S MARTIAL STATUS: Married: _____ Single: _____ Divorced:_____ Separated:_____ Legal Guardian: _____

Legal Guardian_____ Relationship to patient_____

Mother's Name: _____ Father's Name: _____

Address (If different above):_____ Address (If different above):_____

_____ Zip_____ _____ Zip_____

Social Security#:_____ DOB:_____ Social Security#:_____ DOB:_____

Employer: _____ Phone:_____ Employer: _____ Phone:_____

Employer Address:_____ Employer Address:_____

City:_____ State:_____ Zip_____ City:_____ State:_____ Zip_____

IN CASE OF EMERGENCY, CONTACT _____ Phone _____ Relationship_____

If not the parent, who is bring the child in today? _____ SS#: _____

Mailing Address _____ City:_____ State:_____ Zip_____

Relationship to Patient _____ Employer: _____

Reason for Visit (Diagnosis) _____

PRIMARY INSURANCE COMPANY _____

Address: _____

Subscriber: _____ Sex _____ DOB: _____ SS#: _____

Patient/Sub Relationship _____

Employer: _____ Policy#: _____ Group# _____

DO YOU HAVE OTHER INSURANCE? YES ____ NO ____ **IS THE CHILD COVERED BY ANY OTHER INSURANCE? YES _____ NO ____**

SECONDARY INSURANCE COMPANY _____Phone _____

Address: _____

Subscriber: _____ Sex _____ DOB: _____ SS#: _____

Patient/Sub Relationship _____

Employer: _____ Policy#: _____ Group# _____

PEDIATRICIAN FAMILY MD _____

Address: _____

Suite_____ City_____ State_____ Zip_____ Phone_____

Which physician are you seeing today? _____

ALL CHARGES ARE DUE AT THE TIME OF SERVICE UNLESS IN-PATIENT HOSPITAL CHARGES

• I hereby authorize the above physician or hospital to obtain records from other sources as may be needed in the treatment of this patient.
• I hereby authorize the Release of Information concerning this patient's treatment to other phyiscians involved in the care and treatment of this patient.
• I hereby authorize the Release of Information to the insurance company as needed to file for charges incurred by this patient.
I hereby authorize payment of insurance benefits otherwise due to me to be made directly to the above physician or hospital. I understand that I am responsible for any amount not covered by the insurance company.
• A copy of this information shall be as valid as the original.

_____ _____

Signature of Parent or Responsible Party Date

Rev 10/07 **Reviewed By:** _____