

**SIBLEY HEART CENTER CARDIOLOGY  
INITIAL HISTORY – 1**

**PATIENT NAME:** \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name and Relationship of Person Completing this Form: \_\_\_\_\_

Reason for this visit:  Evaluate Heart Murmur  Chest Pain  Palpitations

Other – Explain: \_\_\_\_\_

Tell me why you are here: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

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

**PAST HISTORY:**

Birth Weight: \_\_\_\_\_  Full Term  Premature: (How Early: \_\_\_\_\_ weeks)

Delivery:  Normal  C-Section  Hospital: \_\_\_\_\_

**HOSPITALIZATIONS, SURGERIES, MAJOR ILLNESSES:**  NONE

<b>Problem:</b>	<b>Age/Date</b>	<b>Problem:</b>	<b>Age/Date</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**REVIEW OF SYSTEMS:** (Please check Normal or Abnormal)

Discussed with family

	<b>Normal</b>	<b>Abnormal</b>	<b>Physician Notes: (Comment on abnormality)</b>
Weight Change or Poor Appetite	_____	_____	_____
Eyes	_____	_____	
Ears, Nose and Throat	_____	_____	
Lungs and/or Breathing	_____	_____	
Heart and/or 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	_____	_____	

**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 \_\_\_\_\_

**Nurse Signature:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_

**First Name:** \_\_\_\_\_

**Date of Visit:** \_\_\_\_\_

**Patient #:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**SIBLEY HEART CENTER CARDIOLOGY  
INITIAL HISTORY – 2**

**FAMILY HISTORY:**  Negative for below

Relative	PROBLEMS	Born with Heart Disease	Born with other problems	Heart Attack (Under 45)	High Blood Pressure	Stroke (Under 50)	High Cholesterol	Sudden Death	Cardiomyopathy	Long QT Syndrome	Passing Out	Pacemaker	Seizures	Heart Surgery	Comments
<b>Brother</b>															
<b>Sister</b>															
<b>Mother</b>															
Mother's Mother															
Mother's Father															
Mother (other relative)															
<b>Father</b>															
Father's Mother															
Father's Father															
Father (other relative)															

Discussed with family

**FAMILY HISTORY NOTES:**

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**SOCIAL HISTORY:**

Parents:            Mother's Age \_\_\_\_\_    Father's Age \_\_\_\_\_  
 Brothers Ages:    \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_  
 Sister's Ages:     \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_    \_\_\_\_\_

Patient School Grade: \_\_\_\_\_

**ALLERGIES:**  NONE

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**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 \_\_\_

**Nurse Signature:** \_\_\_\_\_    **Patient Name:** \_\_\_\_\_  
**Physician Signature:** \_\_\_\_\_    **Patient #:** \_\_\_\_\_  
**Date of Visit:** \_\_\_\_\_    **DOB:** \_\_\_\_\_