

## Existing Patient Intake Form

<b>Patient Registration Information</b>		
Name:		Date of Birth:
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Decline to provide <input type="checkbox"/> Other	Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Decline to provide	
Preferred language (if not specified, English will be chosen as your preferred language):		
Contact preference: <input type="checkbox"/> Mobile /texting <input type="checkbox"/> Home Phone <input type="checkbox"/> Work Phone <input type="checkbox"/> Email (provide email address) To receive text message, opt in by texting "Sibley" to 622622		
Home Address:	Mailing Address (if different)	
Home Phone:	Mobile Phone:	Work Phone:
<b>Reason for visit / diagnosis:</b> <input type="checkbox"/> Routine follow-up <input type="checkbox"/> New problem / diagnosis _____		
<b>Primary Care Physician:</b>	<b>Referring Physician:</b>	
<b>Pharmacy:</b> Name: _____ Address: _____		
<b>Guarantor / Responsible Party (changes since last visit)</b> <input type="checkbox"/> N/C (no changes)		
Name:		Date of Birth:
Relationship to patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Family Member <input type="checkbox"/> Other _____		
Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Other _____		
Home Address:	Mailing Address (if different)	
Home Phone:	Mobile Phone:	Work Phone:
<b>Emergency Contact(s) (changes since last visit)</b> <input type="checkbox"/> N/C (no changes)		
Name:		Phone:
Relationship to patient: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Family Member <input type="checkbox"/> Other _____		
Home address:	City:	State:      Zip:
Name:		Phone:
Relationship to patient: <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Family Member <input type="checkbox"/> Other _____		
Home address:	City:	State:      Zip:
<b>Insurance (changes since last visit)</b> <input type="checkbox"/> N/C (no changes)		
<b>PRIMARY INSURANCE</b> Name:		<b>SECONDARY INSURANCE</b> Name:
Subscriber/Member ID #:		Subscriber/Member ID #:
Group #		Group #
Subscribe Name:		Subscribe Name:
Address:		Address
Employer:		Employer:
Date of Birth:		Date of Birth:
Relationship to patient:		Relationship to patient:

**ALL CHARGES ARE DUE AT THE TIME OF SERVICE**

- I hereby authorize Sibley Heart Center Cardiology (Sibley) 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 physicians involved in the care and treatment of this patient.
- I hereby authorize payment of insurance benefits otherwise due to me to be made directly to Sibley 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**

MRN# \_\_\_\_\_ 1

<b>Patient Name:</b> _____	<b>Date of Birth:</b> _____
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**General Cardiovascular Symptoms: Check all that apply to the patient**

- Chest pain     Cyanosis     Sweating     Edema (swelling)     Exercise intolerance     Poor appetite  
 Inability to keep up with peers     Shortness of breath at rest     Shortness of breath w/mild exercise  
 Fainting     Dizziness     Palpitations     No concerning symptoms     Other \_\_\_\_\_

**Review of Systems**

Weight change or poor appetite <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Bones / Joints <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Eyes <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Skin <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Ears <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Nervous system <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Nose <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Emotional/Behavioral <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Throat <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Blood / Lymph system <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Heart /Circulation <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Hormones / Glands <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Stomach /Digestion <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Allergic /Immunologic <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal
Kidneys /Bladder <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Respiratory <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal

**Allergies: (changes since last visit)**     N/C (no changes)

Yes     None    If Yes, please list:


Immunizations up to date:  Yes     No     Declined

**Past History: (changes since last visit)**     N/C (no changes)

Hospitalizations, Surgeries, Major Illnesses:

Problem: _____	Date / Pt age: _____
Problem: _____	Date / Pt age: _____
Problem: _____	Date / Pt age: _____
Problem: _____	Date / Pt age: _____
Problem: _____	Date / Pt age: _____

**Patient Medical History (changes since last visit)**     N/C (no changes)

ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No	G-tube <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle cell anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Glenn <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Trisomy 21 <input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral valve replace <input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic lung disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberous sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Nissen fundoplication <input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Turner syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No	Norwood <input type="checkbox"/> Yes <input type="checkbox"/> No
DiGeorge syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No	Arterial switch <input type="checkbox"/> Yes <input type="checkbox"/> No	PDA ligation <input type="checkbox"/> Yes <input type="checkbox"/> No
GERD <input type="checkbox"/> Yes <input type="checkbox"/> No	ASD repair <input type="checkbox"/> Yes <input type="checkbox"/> No	PE tubes <input type="checkbox"/> Yes <input type="checkbox"/> No
Kawasaki disease <input type="checkbox"/> Yes <input type="checkbox"/> No	AVR <input type="checkbox"/> Yes <input type="checkbox"/> No	TOF repair <input type="checkbox"/> Yes <input type="checkbox"/> No
Muscular dystrophy <input type="checkbox"/> Yes <input type="checkbox"/> No	BT shunt <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillectomy <input type="checkbox"/> Yes <input type="checkbox"/> No
Obesity <input type="checkbox"/> Yes <input type="checkbox"/> No	CAVC repair <input type="checkbox"/> Yes <input type="checkbox"/> No	Adenoidectomy <input type="checkbox"/> Yes <input type="checkbox"/> No
Sleep apnea <input type="checkbox"/> Yes <input type="checkbox"/> No	Coarctation repair <input type="checkbox"/> Yes <input type="checkbox"/> No	VSD repair <input type="checkbox"/> Yes <input type="checkbox"/> No
Prematurity <input type="checkbox"/> Yes <input type="checkbox"/> No	Fontan <input type="checkbox"/> Yes <input type="checkbox"/> No	

Nurse signature: \_\_\_\_\_  
 Physician signature \_\_\_\_\_  
 Date of visit: \_\_\_\_\_

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MRN# \_\_\_\_\_

<b>Patient Name:</b> _____	<b>Date of Birth:</b> _____
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<b>Family Medical History: Check all that apply (changes since last visit)</b>																		<input type="checkbox"/> N/C (no changes)			
Relation	Name	Age/ Status	Heart defect at birth	Heart surgery	Heart attack	High blood pressure	Stroke	Dyslipidemia	Diabetes	Obesity	Cardiomyopathy	Pacemaker	Sudden death	Long QT Syndrome	Drowning	Passing out	Seizures	Marfan's syndrome	Deafness at birth	Other	
Mother																					
Father																					
Sister																					
Brother																					
Maternal Grandmother																					
Maternal Grandfather																					
Paternal Grandmother																					
Paternal Grandfather																					
OTHER																					

<b>Social History: Check all that apply to the patient (changes since last visit)</b>		<input type="checkbox"/> N/C (no changes)
Exercise: <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily <input type="checkbox"/> Competitive athlete <input type="checkbox"/> Recreational		
Diet: <input type="checkbox"/> Usual American <input type="checkbox"/> Low fat <input type="checkbox"/> Low salt <input type="checkbox"/> Vegetarian <input type="checkbox"/> Other _____		
Smoking: <input type="checkbox"/> N/A <input type="checkbox"/> No. of packs a day _____ <input type="checkbox"/> Age started _____		
Alcohol: <input type="checkbox"/> N/A <input type="checkbox"/> Type: _____ <input type="checkbox"/> Amount: _____ day/week/month		
Sexual activity: <input type="checkbox"/> N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Currently pregnant		

<b>Current Medications: (list all medications including over the counter medications/vitamins)</b>	
1.	2.
3.	4.
5.	6.
7.	8.
9.	10.
11.	12.

Does patient take antibiotics prior to dental procedures, operations or appointments?  Yes  No

Nurse signature: \_\_\_\_\_  
 Physician signature \_\_\_\_\_  
 Date of visit: \_\_\_\_\_

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MRN# \_\_\_\_\_