

JACKSONVILLE PEDIATRIC AND ADULT CONGENITAL CARDIOLOGY
INITIAL HISTORY

PATIENT'S NAME: _____ Date of Birth: _____ Date of Visit: _____
 Name of Person Completing this Form: _____ Relationship to Patient: _____
 Primary Care Physician: _____ Physician's Phone Number: _____

Reason for Visit: Heart Murmur Chest Pain Palpitations Difficulty with Exercise Dizziness Fainting
 Hypertension Cholesterol Other _____

Birth History: Birth Weight _____ Full Term: Yes No Premature: (How many weeks early? _____)
 Delivery: Normal C-Section Hospital: _____

DRUG AND/OR OTHER ALLERGIES: NONE

IMMUNIZATIONS: Up to Date: Yes No

Past Medical/Surgical History: (include Hospitalizations, Surgeries, All Significant Illnesses)

Medications: None (list all being taken NOW)

Drug Name	Directions for Use	Drug Name	Directions for Use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Review of Systems:	Normal	Abnormal	Physicians notes
Weight change	_____	_____	_____
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	_____	_____	_____
Central Nervous System	_____	_____	_____
Emotional or Behavioral Issues	_____	_____	_____
Skin and /or Allergies	_____	_____	_____

CHECK ALL THAT APPLY TO PATIENT:

Exercise : None Occasional Daily Athlete: Competitive Recreational
 Diet: Usual Low Fat Low Salt Vegetarian Other: _____
 Feeding (Infants): Breast Formula Brand Name _____ No Oz/Feed _____ Frequency _____
 Feeding Notes: _____

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