**Newport Harbor Cardiology, Inc.**
601 Dover Drive, Suite 2, Newport Beach, CA 92663

# HEALTH HISTORY QUESTIONNAIRE (INFANT/TODDLER)

Patient Name: _____ Date of Birth: _____

Primary Care Provider: _____ Reason for Visit: _____

List any other provider(s) who should receive records from today's visit_____

| **Please mark the column if your child has had any of the following symptoms:** | | | | |
|---|---|---|---|---|
| | Fast breathing | | | Swelling of face, hands, or legs |
| | Difficulty breathing | | | Cough |
| | Blueness (cyanosis) | | | Passing out |
| | Sweating during feeding | | | Rapid heart beat |
| | Shortness of breath during feeding | | | Difficulty with weight gain or growth |
| | Unusual shortness of breath with exertion | | | |

| **Please mark the column if your child has had other problems or symptoms related to any of the following:** | | | | |
|---|---|---|---|---|
| | Headaches | | | Seizures |
| | Eyes | | | Developmental delay |
| | Ear, Nose, Throat | | | Skin |
| | Feeding | | | Bleeding |
| | Chronic diarrhea or constipation | | | Bruising |
| | Kidney or bladder | | | Allergies |
| | Muscles | | | Diabetes |
| | Bones | | | Mental Health |

| **Does your child take any medications:** ___**Yes** ___**No** | | |
|---|---|---|
| If yes, what medication? | How much? | How often? |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| | | |
| **Is your child allergic to any mediations:** | ___**Yes** | ___**No** |
| If yes, what medication? | | |
| 1. | | |
| 2. | | |
| | | |
| **Are your child's immunizations up to date:** | ___**Yes** | ___**No** |

| Health History | | | |
|---|---|---|---|
| | Yes | No | Comment: |
| Problems during pregnancy? | | | |
| Cesarean Section? | | | |
| Problems After Pregnancy? | | | |
| Child's birth weight | | | |
| Was your child premature? | | | |
| Does your child have any chronic health problems? | | | |
| Past hospitalizations? | | | |
| Past Surgical Procedures? | | | |
| Is your child fed through a tube? | | | |
| What does your child eat? | ___Breast milk ___Bottle milk ___Regular foods | | |

| Family History | | |
|---|---|---|
| Was anyone in your family born with a heart defect? | ___Yes ___No | Describe: |
| Have any family members died suddenly at an early age? | ___Yes ___No | Describe: |
| Have any family members required a pacemaker? | ___Yes ___No | Describe: |
| Have any family members had early heart attacks? (males <55 yo, females <65yo) | ___Yes ___No | Describe: |
| | | |

**Do you have any of these problems on either side of your family? Check all that apply.**

| | |
|---|---|
| ___ Children born with other birth defects | ___ Abnormal/fast/irregular heartbeat or arrhythmia |
| ___ Children who have had heart surgery | ___ High blood pressure |
| ___ SIDS or infant death under 1 year of age | ___ High cholesterol |
| ___ Unexplained death or drowning | ___ Asthma |
| ___ Stroke under 55 years of age | ___ Diabetes, type 1 (requiring insulin) |
| ___ Pacemaker or defibrillator under 55 years of age | ___ Diabetes, type 2 (not requiring insulin) |
| ___ Death from cardiac cause under 55 years of age | ___ Thyroid disease |
| ___Death from non-cardiac cause under 55 years of age | ___ Lupus |
| ___ Fainting | ___ Cancer (Please specify: _____) |
| | ___ Seizures |
| | ___ Migraine headaches |

_____ _____

Signature Date

_____

Print name/ Relationship to patient