

REVIEW OF SYSTEMS

Patient Name: _____ **Date of Birth:** _____

PATIENT HISTORY (CHECK ALL THAT APPLY) * Use back of sheet if more room is needed *

- | | | |
|----------------------------------------------------------|------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Open Heart surgery | <input type="checkbox"/> Heart catheterization | <input type="checkbox"/> MRI or CT scan |
| <input type="checkbox"/> Echocardiogram | <input type="checkbox"/> Pneumonia or asthma | <input type="checkbox"/> Kidney, liver, GI problems |
| <input type="checkbox"/> Seizures or neurologic problems | <input type="checkbox"/> Non-cardiac surgery | <input type="checkbox"/> Major illness |
| <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Tuberculosis | |

Please explain those checked above, including approximate dates: _____

SOCIAL HISTORY

What is the patient's current living arrangements? _____
(e.g., living together with both parents, parent divorced & share custody, foster care, guardianship, etc.)

Does the patient have any brothers, sisters, pets? _____

What grade is the patient currently in? _____
(daycare, preschool, elementary, high school, college, etc.)

What sports or activities does the patient enjoy? _____

Please list any exposure the patient has to tobacco, drug, or alcohol use at home or school. _____

FAMILY HISTORY (CHECK ALL THAT APPLY)

- | | | |
|----------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------|
| <input type="checkbox"/> Heart disease in children | <input type="checkbox"/> Hypertrophic Cardiomyopathy | <input type="checkbox"/> Genetic syndromes |
| <input type="checkbox"/> Sudden death | <input type="checkbox"/> Long QT Syndrome | <input type="checkbox"/> Heart surgery |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drowning | <input type="checkbox"/> Arrhythmia |
| <input type="checkbox"/> Psychiatric or anxiety disorder | <input type="checkbox"/> Deafness | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart attack at young age (< 50) | |

Please explain those checked above: _____

RECENT PATIENT HEALTH (CHECK ALL THAT APPLY)

GENERAL

- chills
- fatigue
- fevers
- recent weight loss
- pregnancy
- poor exercise ability

SKIN

- rashes
- tick bites

LUNGS

- short of breath
- wheezing
- bronchitis or pneumonia

HEART

- murmur
- palpitations
- chest pain
- leg cramping

GASTROINTESTINAL

- reflux
- liver problems
- loss of appetite
- stomach pain
- constipation
- vomiting

HEAD

- dizziness
- headaches
- hearing problems
- nose bleeds

BLOOD

- bleeding
- blood clots
- anemia
- anesthesia reaction

NEUROLOGICAL

- fainting
- seizures

PSYCHIATRIC

- stroke
- anxiety disorder
- depression
- ADHD

Parent/patient signature: _____ Date: _____

Please review and update as needed at subsequent clinic visits, initial and date below (every six months for frequent visitors)

Initials: _____ Date: _____ Initials: _____ Date: _____ Initials: _____ Date: _____

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Parent/patient signature: _____ Date: _____

Please review and update as needed at subsequent clinic visits, initial and date below (every six months for frequent visitors)

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