UAB PEDIATRIC CARDIOLOGY
ADULT OUTPATIENT DATA FORM

Date: _____

The information requested on this form is necessary for cardiology records. Please help us in giving care to you or your child by filling in the form as completely as possible and bring it to your or your child's clinic appointment. All information will be held in strictest confidence. **PLEASE PRINT.**

Why are you here to see the cardiologist?_____

Patient's Name

_____

LAST FIRST MIDDLE SUFFIX (II, Jr.) Name the patient goes by

Date of Birth: _____

MEDICATIONS

List all medications (prescriptions, over the counter, birth control)_____

_____

Allergies to medications:_____

_____

PAST MEDICAL HISTORY

List all major illnesses or surgeries since the last visit here including when they occurred and the doctor who cared for the patient during the illness

_____

_____

If new patient: Has a cardiologist previously diagnosed heart disease? No_____ Yes _____ If Yes, please list previous cardiologists, operations, locations:_____

_____

FAMILY HISTORY

Has any immediate family member ever seen a cardiologist before? (Name, relationship and doctor's name)

_____

_____

Are there family members with the following diseases?

NO	YES	EXPLAIN WHO HAS THIS DISEASE
		Heart disease before 50 years old
		Sudden unexpected death before 50 years old
		High blood pressure
		Seizures
		Syndromes or genetic disorder (Down's, Marfan's, Sickle cell anemia, etc)
		Asthma
		Other (please explain)

Additional comments: _____

SOCIAL HISTORY

Occupation:

Employer:_____

RecreationalActivities/Hobbies:_____

Exercise: No_____ Yes:_____ Type:_____

Ever Smoking?: No_____ Yes_____packs/day_____ Smokers in the house: No_____ Yes_____

Alcohol: No_____ Yes_ Occasional_____ Street/Recreational drug use: No_____ Yes_____

Marital Status:(circle) Single Married Separated Divorced Widowed

# of children_____ If female, # of pregnancies:_____

Please help us give you the best possible care by providing us with complete information on any physicians that you see that will need a copy of our office reports:

Name: _____ Specialty: _____

City: _____ State: _____ Zip; _____

Office Phone : _____ Office Fax: _____

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Please help us give your child the best possible care by providing us with complete information on any physicians that your child sees that will need a copy of our office reports:

Name: _____ Specialty: _____

City: _____ State: _____ Zip; _____

Office Phone : _____ Office Fax: _____

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Please help us give your child the best possible care by providing us with complete information on any physicians that your child sees that will need a copy of our office reports:

Name: _____ Specialty: _____

City: _____ State: _____ Zip; _____

Office Phone : _____ Office Fax: _____

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Please help us give your child the best possible care by providing us with complete information on any physicians that your child sees that will need a copy of our office reports:

Name: _____ Specialty: _____

City: _____ State: _____ Zip; _____

Office Phone : _____ Office Fax: _____

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CONSENT TO CONVERSE

I, _____, parent/legal guardian of _____, DOB: _____,

Print name of patient

Give UAB Division of Pediatric Cardiology and the Alabama Congenital Heart Disease Center permission to speak with the following person(s) regarding all aspects of my/their medical conditions.

NAME:	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list anyone who you specifically **DO NOT** want UAB Division of Pediatric Cardiology or The Alabama Congenital Heart Disease Center to speak with about you/your child.

_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

(Patient/Parents/Legal Guardian) **Date**