UAB PEDIATRIC CARDIOLOGY
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 _____ Sex _____ Race _____Social Security Number _____

MEDICATIONS

List all medications (prescription and over the counter)_____

_____

Allergies to medications:_____

_____

PAST MEDICAL HISTORY

Birth Weight _____ Was the patient delivered (please circle) early on time late

Were there any complications during pregnancy or delivery or right after?_____

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 cardiologist previously diagnosed heart disease? No____ Yes____ If yes, please list previous cardiologist, 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 DISESAE	
		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.)	
		Immune deficiency	
		Asthma	
		Other (please explain)	

Additional comments: _____

SOCIAL HISTORY

Patient Lives with: Mother ___ Father ___ Mother/Father___ Mother/Mother ___ Father/Father ___ Grandparent/Other _____

Are there smokers in the home? Yes_____ No_____ Does the house have city water? Yes _____ No _____ Pets in the house? Yes_____ No_____

List hobbies the patient enjoys_____

Marital status of Parents: (circle) Single Married Separated Divorced Widowed

PARENT 1 NAME AND OCCUPATION_____

PARENT 2 NAME AND OCCUPATION_____

CAREGIVER/GUARDIAN NAME (if different from parent)_____

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:

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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**