



FOLLOW UP VISIT QUESTIONNAIRE – PEDIATRIC CARDIOLOGY

__Dr. Carroll__ Dr. Dayton__ Dr. Flynn__ Dr. Mirani__ Dr. Steinberg

Patient Name _____ Date _____

Person Filling out Form: _____ Relationship to Patient: _____

Primary Care Physician: _____

Interval History:

Cardiac:

Since the last visit has there been any new health problems not related to the heart?

Since the last visit have there been any hospitalizations? _____

Have there been any new health problems? _____

Social History: (Skip if patient is < 10 years old)

Does the patient: Drink Alcohol? _____ Use Street Drugs? _____

Smoke Cigarettes> _____ Chew Tobacco? _____

Since the last visit have there been any changes in:

Who lives at home with the patient: _____

School the patient attends (if any): _____

Physical activities in which the patient participates in: _____

Caffeine use by Patient: Never: _____ Sometimes: _____ Frequent: _____

Medications Currently Taking or Prescribed:

Medications: _____ Amount: _____ Times/Daily: _____ Taking: Yes or No

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Medications: _____ Amount: _____ Times/Daily: _____ Taking: Yes or No

Medications: _____ Amount: _____ Times/Daily: _____ Taking: Yes or No

Allergies:

To Medications: _____

Other Allergies: _____

Miscellaneous:

Have there been any other major changes since the last visit? _____