AdventHealth
Medical Group

NEW PATIENT FORM

ROOM #: _____

PATIENT NAME: _____ DATE OF BIRTH: _____ AGE: _____ DATE: _____

Referring Physician: _____ Primary Care Physician: _____

HISTORY - COMPLETED BY PATIENT / PARENT

1. Reason for your visit today _____
2. Please indicate if you (the patient) are having any current problems, signs or symptoms in any of the following areas:

	No	Yes		No	Yes
Fever, weight loss, fatigue, etc.	❑	❑	Neurological	❑	❑
Eyes	❑	❑	Allergies	❑	❑
Ears, Nose, Mouth, Throat	❑	❑	Thyroid / Endocrine	❑	❑
Stomach / Digestion	❑	❑	Psychiatric	❑	❑
Lungs / Breathing	❑	❑	Blood / Lymph	❑	❑
Heart / Circulation	❑	❑	Skin	❑	❑
Muscle / Joints / Bones	❑	❑	Urinary / Reproductive	❑	❑

3. **PAST MEDICAL HISTORY:**

Gestational Age _____ weeks _____
Birth weight _____
Date of last dental checkup? _____

Has the patient been diagnosed with a heart murmur?	❑ NO	❑ YES
Any history of being blue or cyanotic?	❑ NO	❑ YES
Any hospitalizations other than for birth?	❑ NO	❑ YES
For what?		
Any serious injuries or illness?	❑ NO	❑ YES
What kind? _____		
Has the patient had any surgeries?	❑ NO	❑ YES
List surgeries _____		
Has the patient been diagnosed with development problems?	❑ NO	❑ YES
Are the patient's immunizations up to date?	❑ YES	❑ NO
Does the patient have asthma?	❑ NO	❑ YES
Is the patient menstruating?	❑ NO	❑ YES
Last menstrual date: _____		
Last Dental Visit: _____		
Has the patient ever seen a cardiologist?	❑ NO	❑ YES
Any prior heart surgeries, caths, Cardiac Ablations?	❑ NO	❑ YES

4. **HAS THE PATIENT HAD ALLERGIC REACTIONS?** ❑ **NO** ❑ **YES**
To what: _____

5. **FAMILY HISTORY:**

What is the Health Status of the patient's family?
Mother: _____ Father: _____ Brother/Sisters: _____

Are there any close relatives born with heart problems?	❑ NO	❑ YES
Is there a history of sudden death in the family?	❑ NO	❑ YES
Are there any family members with pacemakers?	❑ NO	❑ YES
Is there a history of hypertrophic cardiomyopathy?	❑ NO	❑ YES
Is there a history of long QT Syndrome in the family?	❑ NO	❑ YES
Is there a history of heart disease, heart attack, heart failure?	❑ NO	❑ YES

FEEDING / NUTRITION (Early Life):

Is your child's appetite usually good?	❑ YES	❑ NO
Is it good now?	❑ YES	❑ NO
Any feeding difficulties?	❑ NO	❑ YES
Any excessive sweating?	❑ NO	❑ YES
Any difficult breathing (hard/fast)?	❑ NO	❑ YES
Current feedings: Breast Milk	❑ YES	❑ NO
Frequency and times _____		
Formula	❑ YES	❑ NO
What type? _____		
Amount/Feed? _____		

GROWTH/DEVELOPMENT:

Do you have any concerns about the growth and development of the patient?	❑ NO	❑ YES

ACTIVITY:

DOES THE PATIENT...

• have exercise limitations?	❑ NO	❑ YES
• get short of breath with exercise?	❑ NO	❑ YES
• get dizzy with exercise?	❑ NO	❑ YES
• get chest pain with exercise?	❑ NO	❑ YES
• pass out with exercise?	❑ NO	❑ YES
• perform adequate activity for age?	❑ YES	❑ NO

MEDICATION:

PresentMedications:_____
_____
_____
_____
_____

6. **PATIENT'S SOCIAL HISTORY:**

Martial Status: ❑ Single ❑ Divorced ❑ Married ❑ Widow/Widower
Current Employer: _____
Who does the patient live with? (Mom, Dad, Sisters, Brothers, Spouse, etc.) _____
Name of school patient attends and grade _____
Does the patients smoke? ❑ No ❑ Yes How many packs per day? _____ For how many years? _____
Does the patient drink alcohol? ❑ No ❑ Yes How many drinks per day/per week/ month? _____
Does the patient use illicit drugs? ❑ No ❑ Yes If yes, what kind? _____
Any forms to be completed? (FMLA, Physical, School Note, etc.) _____

Parent / Legal Guardian Signature _____ Date _____
Physician Signature _____ Date _____

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NAME: _____ DOB: _____ AGE: _____ DATE: _____
HPI: _____ Referring Physician: _____

BP_____ HR _____ Resp. Rate_____ Oximetry_____ % Ht_____ (_____%) Weight _____ (_____%)
Appearance: well developed, well nourished, obese, thin, cachetic

Head and Face: Normal _____
Eyes: Conjunctive and lids Normal _____
Ears/Nose/Mouth/Throat:
Teeth, gums, palate Normal _____
Oral mucosa Normal _____
Neck: Jugular veins (distension) Normal _____
Thyromegaly Absent _____

Respiratory
Respiratory Effort/ Palpitation
Auscultation/breath sounds
Gastrointestinal
Abd for Tenderness/Masses
Hepatosplenomegaly
Bowel Sounds
Neuro/Psych: Brief assessment mental status
orientation to time, place and person
Mood/affect (depression, anxiety, agitation)
Cardiovascular
Palpitation of heart (size, PMI)
Auscultate - murmurs, rubs, clicks
Regular rate & rhythm
Abd. Aorta (bruits)
Carotid arteries (bruits)
Femoral pulses
Pedal Pulses
Extremity edema
B/P in 2 or more for coarctation

Chest (Breasts) Normal _____
Musc: Clubbing _____
Exam of gait & station Normal _____
Inspection digits, nails Normal _____
Assessment of strength Normal _____
Integ: Acyanotic, Cyanotic Normal _____
Rashes/papular/vesicular
Lesions, ulcers, erythema
Irregular margins
Induration, nodules
Hematoligic/Lymphatic Normal _____

ASSESSMENT:

PLAN:

ALLERGIES: _____

MEDICATIONS: _____

❑EKG ❑ECHO ❑HOLTER ❑GXT
Indication: _____

Test Next Visit: ❑EKG ❑ECHO ❑HOLTER ❑GXT
SBE Card Provided: _____YES _____NO
Exercise Restrictions: _____YES _____NO _____TYP
Hand Out Given: _____YES _____NO

Physician Signature_____ Date _____

❑ ORLANDO ❑ VIERA ❑ PORT ORANGE ❑ TAVARES ❑ SEBR