HEALTH INTAKE FORM: NEW FETAL ECHOCARDIOGRAM

Date: _____
Patient Name: _____

Welcome to Capital District Pediatric Cardiology. Please take a few minutes to answer some background health questions regarding your fetal echocardiogram with us today. Answer as best as you can on both the front and back of this sheet. If more space is needed, please feel free to use the space on the back side of this sheet. Your doctor will go over everything with you during your visit, and answer all of your questions. PLEASE RETURN THIS FORM TO THE FRONT DESK PRIOR TO YOUR VISIT. Thanks!

Reason/Main Concern For Your Visit Today: _____

Primary obstetrician and any other specialist seen during the pregnancy:
1)_____ 2)_____ 3)_____

Due Date: _____
Number of previous pregnancies: _____
Number of living children: _____
Any abnormalities on OB ultrasound: _____

Patient's Current Medications:

	Medication Name	Dose/Amount	Frequency/times per day
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____

Patient's Allergies to Any Medications:

	Medication Name:	If allergic, type of reaction
1)	_____	_____
2)	_____	_____

Family History:

Any parent, sibling, grandparent or aunt/uncle:			
	born with a congenital heart defect?	Yes	No
	with a history of an irregular or abnormal heart rhythm?	Yes	No
Any family member with Tuberous Sclerosis		Yes	No
Any family member with autoimmune diseases such as Lupus		Yes	No

Patient Review of Systems:
Does the patient have a history of:

Smoking	Yes	No
Type 1 or 2 Diabetes (before pregnancy)	Yes	No
Autoimmune disease such as Lupus	Yes	No

Are there any other concerns or questions for today's visit?

Please use the space below for any additional information.

PLEASE RETURN THIS FORM TO THE RECEPTIONIST AT THE FRONT DESK (EVEN IF NOT COMPLETED) PRIOR TO YOUR VISIT.