Hypertension Program

Children's Healthcare of Atlanta

Patient questionnaire

Referring Physician: _____ Phone: _____

PATIENT INFORMATION

First Name: _____ MI: ____ Last Name: _____

Date of Birth: _____ Gender (check one): _____ Male _____ Female

Address: _____

City: _____ State: _____ Zip Code: _____

LEGAL GUARDIAN

First Name: _____ MI: ____ Last Name: _____

Relation to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Other Phone: _____

PATIENT MEDICAL HISTORY

1. Has your child's blood pressure been normal in the past? □ No □ Yes

   Date of high blood pressure reading: _____ BP reading: _____

2. Did your child have high blood pressure on multiple office visits? □ No □ Yes

   If "yes", please list number of visits: _____

3. Is your child currently being treated for high blood pressure? □ No □ Yes

   If "yes", please explain: _____

   _____

4. Has your child been evaluated for high blood pressure in the past? □ No □ Yes

   If "yes", describe when and what types of tests your child received:

   _____

   _____

5. Is your child allergic to any medications? □ No □ Yes

   If "yes", please list medications: _____

6. Is your child taking any prescription, herbal or over-the-counter medications? □ No □ Yes

   If "yes", please list medications: _____

   _____

7. Please check if you child has experienced any of the following:

   _____ Weight gain or loss (during the past 6 to 12 months)

   _____ Heart disease

   _____ Kidney disease or problems with kidneys

   _____ Bladder infections

   _____ Trouble sleeping (snoring, abnormal breathing patterns)

   _____ Headaches with fast heart beat and sweating

   _____ Injury to back or abdomen

   _____ Significant medical illness (explain: _____)

   _____ Hospitalization or surgery (explain: _____)

   _____ Premature birth or low birth weight

8. Describe any other problems your child has been experiencing due to high blood pressure:

   _____

   _____

9. Is your child currently on any dietary restrictions? □ No □ Yes

   Explain: _____

   _____

10. Is your child physically active? □ No □ Yes

11. Describe activities and/or sports in which your child participates and how often:

    _____

    _____

FAMILY MEDICAL HISTORY

Has anyone in your immediate family experienced any of the following? *(check all that apply)*

_____ High blood pressure

_____ High cholesterol

_____ Diabetes

_____ Kidney disease

_____ Heart attack, heart surgery or stroke before age 55

Please bring this completed form with you to your visit. Call **404-785-3607** if you have any questions.