PRINCETON NASSAU
PEDIATRICS

*Pre-Visit Questi*onnaire - Age 11 yrs and over Well visit

TO BE COMPLETED BY PARENT/GUARDIAN (IF <18yo)
Or BY PATIENT IF Age 18 or over

Do you have any concerns, questions, or problems that you would like to discuss today? □ none / or **provide details:**

List any medications, vitamins or supplements: □ none / or **provide details:**

Have there been any significant changes in the family or in the patient's medical history since the last well visit? □ none / or **provide details:**

Tuberculosis Screening:
Was this patient born in a country at high risk for Tuberculosis (countries other than the United States, Canada, Australia, New Zealand or Western Europe)? □ no / or **provide details:**

Has a family member or close contact had tuberculosis or a positive tuberculin skin test? □ no / or **provide details:**

Is this patient infected with HIV? □ no / or **provide details:**

Cardiac Screening:
Does this patient have parents or grandparents who have had a stroke or heart problem before age **55** or unexplained sudden death before age **50**? □ no / or **provide details:**

Does this patient have a parent with an elevated blood cholesterol (240mg/dl or higher) or who is taking cholesterol medication?
□ no / or **provide details:**

Does anyone in the family **have a genetic heart problem** such as hypertrophic cardiomyopathy (HCM), Marfan Syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long or short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)? □ no / or **provide details:**

Has anyone in your family had a pacemaker or implanted defibrillator before age 35? □ no / or **provide details:**

Has this patient ever passed out or nearly passed out during or after exercise**,** had chest pain, pressure or tightness during exercise, gotten lightheaded/felt more short of breath than expected with exercise or complained about heart racing or skipped beats during exercise?
□ no / or **provide details:**

Has this patient ever had a heart issue (ex. high blood pressure, high cholesterol, Kawasaki Disease, heart murmur, heart infection) or a test to evaluate the heart (ex. ECK/ECG, echocardiogram)? □ no / or **provide details:**

Has this patient ever had a seizure? □ no / or **provide details:**

Allergy History:
Does this patient have any life threatening allergies, if yes to what and what are the known reactions? □ no / or **provide details:**

If this patient has allergies, has an epinephrine auto injector ever been recommended? □ yes / □ no / □ not applicable
If yes, is your prescription up do date? □ yes / or **provide details:**