Follow-up Patient Questionnaire

Name: ____

Who is with the patient today? ___________________ Relationship:___________________

What concerns do you have today, if any?

____

____

Has the patient experienced any of the following symptoms since the last visit?

Babies/toddlers only:

- ☐ Poor feeding
- ☐ Sweating with feeds
- ☐ Poor weight gain
- ☐ Unusual irritability
- ☐ Cyanosis (turning blue)
- ☐ **None of the above**

All patients: Do you have any concerns about the following:

- ☐ Motor skills
- ☐ Language skills
- ☐ Social/emotional development
- ☐ Learning/academic skills
- ☐ **No developmental concerns**

All patients: Since your last visit, have you experienced any of the following:

- ☐ Breathing difficulty
- ☐ Trouble with exercise
- ☐ Abnormal fatigue
- ☐ Fainting
- ☐ Chest pain
- ☐ Palpitations (fast or irregular heart rate)
- ☐ Lightheadedness
- ☐ **No symptoms at all**

Current medications taken for the patient's heart:

Medication	Dose	Medication	Dose
_______________________	_____________	_______________________	____________
_______________________	_____________	_______________________	____________

Other medications:

_______________________________ _________________________________

_______________________________ _________________________________

Any new heart-related family history to report?

- ☐ Yes – please explain: ____
- ☐ No

Current grade, if applicable: ______________ School: _______________________________

Is the patient physically active?

- ☐ Not active at all
- ☐ Active play (young children)
- ☐ Recreational sports (friends, parks and rec, etc.)
- ☐ Competitive sports (which ones: ____)
- ☐ Individual workouts

Does patient use any of the following:

- ☐ Tobacco
- ☐ Vaping/nicotine
- ☐ Alcohol
- ☐ Recreational drugs (which ones: ______________________)
- ☐ Energy drinks
- ☐ Other caffeine

Anything else you would like us to know?

____

____

____

____

Date: ___________________

Patient's Name: _____________________________________ DOB: ______________

Covid-19 Questionnaire

Because Covid-19 infection and vaccination can affect the heart, it is helpful for us to know your Covid history. Please answer the following questions to the best of your ability.

1. Has the patient been vaccinated against Covid-19?

   ☐ No

   ☐ Yes: ☐ Pfizer ☐ Moderna ☐ J&J

   ☐ One shot

   ☐ Two shots

   ☐ Two shots plus booster

   Approximate date of last vaccine: __________________

2. Has the patient had a Covid-19 infection?

   ☐ No

   ☐ Yes

   If yes:

   Approximate date of infection: ______________________

   Any symptoms during infection? ☐ No ☐ Yes

   Hospitalized? ☐ No ☐ Yes

   How many days of fever? ____________

   If patient had symptoms:

Symptom	**Had during illness**	**Still present**
Cough	☐	☐
Congestion/runny nose	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Muscle aches	☐	☐
Loss of taste/smell	☐	☐
Sore throat	☐	☐
Nausea/vomiting	☐	☐
Diarrhea	☐	☐
Fatigue	☐	☐
Headache	☐	☐

Children's Heart Center of Central Oregon

HIPAA ACKNOWLEDGEMENT FORM

Patient Name: ___________________________________ DOB:__________________

The Privacy Act of the Health Information Portability and Accountability Act (HIPAA) of 1996 was placed into effect to protect your Personal Health Information (PHI) from being disclosed to unauthorized persons.

The HIPAA Notice available on our website (hard copies available at our clinic location) is our privacy policy, and explains how your PHI may be used or disclosed as well as your rights for access and control of your PHI. This Notice is effective going forward. A new acknowledgement form will be reissued if there are significant changes to this policy.

Please sign this form to acknowledge that you have received and read a copy of our privacy policy, or that you have declined to read a copy. If you have any questions regarding the privacy policy, please ask a member of our staff.

Form completed by (print)____________________________________ for the above patient.

Signature: __________________________________ Date: ____________________

Patient Name: ____ DOB: _______________

MISSED APPOINTMENT (NO-SHOW) POLICY

Patient Name: _____________________________________ DOB: _____________________

Please **read carefully**, and **initial** below:

At CHCCO, our goal is to provide excellent service in a timely manner, and we need your help.

Canceled appointments, missed appointments, and arriving late for an appointment all affect our ability to stay open, on schedule, give timely appointments to patients who need them, and provide an excellent level of care. We make an effort to be accommodating in our scheduling, so that the needs of our patients can be met. Although we have always asked our patients and their families to notify us if they will be unable to make their appointment, circumstances have made it necessary for us to implement a Missed Appointment Policy. We want to make certain that appointments are kept available for those patients who need and desire them.

_____(initial) If I am unable to come to my appointment, I will notify CHCCO as soon as possible, and no later than **24 hours** before the appointment.

_____(initial) If I don't show for an appointment, or if I reschedule within 24 hours of my appointment, I will be charged a fee of $100, and this will not be covered by my health insurance plan.

_____(initial) If I am more than 15 minutes late for an appointment, the appointment may need to be rescheduled.

_____ (initial)Patients with multiple no-shows will not be rescheduled, so that appointment times can be made available to those who need and desire them.

I, (print)____ (patient or responsible party), acknowledge that I have read and understand the statements above, and that I am responsible for charges to my account.

____ __________________

Signature Date