pediatrix
CARDIOLOGY OF SOUTH FLORIDA

MADELEEN M. MAS, MD, F.A.A.P., F.A.C.C.
CLAUDIA V. PEREIRA, MD, F.A.A.P., F.A.C.C
JOSE PUMARINO, MD. F.A.A.P., F.A.C.C
MEGAN NATALIE, ARNP
Diplomate, American Boards of Pediatrics and Pediatric Cardiology
PRACTICE LIMITED TO CARDIOVASCULAR DISEASES IN THE FETUS, INFANTS, CHILDREN AND YOUNG ADULTS

MEDICAL INFORMATION

Date:_____

Name:_____Dob:_____

PERSONAL MEDICAL HISTORY

1. Diabetes	YES ( )	NO ( )
2. Hypertension	YES ( )	NO ( )
3. Heart disease	YES ( )	NO ( )
4. Kidney Disorders	YES ( )	NO ( )
5. Seizures Disorders	YES ( )	NO ( )
6. Psychiatric Disorders	YES ( )	NO ( )
7. Lupus / Autoimmune Disorders	YES ( )	NO ( )
8. Asthma	YES ( )	NO ( )
9. Any other Disorders	YES ( )	NO ( )
10. Medications	YES ( )	NO ( )

Last Menstrual Cycle date _____
Blood Type _____
Allergies to Medication _____
Have you had any surgeries **YES ( ) NO ( )**
Type of surgeries _____
Are you currently on any medications **YES ( ) NO ( )**
Do you smoke? **YES ( ) NO ( )**
Do you drink? **YES ( ) NO ( )**
Do you take recreational drugs? **YES ( ) NO ( )**
Are there any reported cases of mental retardation, learning disabilities or birth defects on either side of the family **YES ( ) NO ( )**

Patient Signature _____

(According to the AIUM and ultrasound examination does not guarantee a normal baby)