

**COMPREHENSIVE LIPID CONTROL CENTER
PEDIATRIC PATIENT HISTORY**

This is a confidential record, and information contained within will not be released except with your permission.

PATIENT NAME: _____ PARENT/GUARDIAN _____
LAST FIRST M.I.

ADDRESS: (Street & Number) _____ (APT. NO.) _____

(City) _____ (State) _____ (Zip Code) _____

HOME/CELL PHONE: _____ BUSINESS PHONE: _____

BIRTH DATE: _____ SEX (M/F): _____ SCHOOL: _____

REFERRING PHYSICIAN: _____ TEL.NO. _____

ADDRESS: _____ FAX.NO. _____

HOSPITALIZATIONS:

YEAR	REASON			

ILLNESSES, INJURIES, ACCIDENTS:

YEAR	ILLNESS			

MEDICATIONS:

Include vitamin/mineral supplements (use other side if necessary)

MEDICATION	DATES	DOSE (Amount)	TIME OF DOSE

DIET:

Has your child ever been instructed to follow a cholesterol-lowering diet? Yes ___ / No ___

Do you know the cholesterol, fat, and saturated fat content in your child's diet? Yes ___ / No ___

Do you think your child is over or underweight? Yes ___ / No ___

Food allergies/intolerance: _____

EXERCISE:

Does your child get exercise at least 3 times per week? Yes ___ / No ___

List exercise/physical activity your child enjoys: _____

T.V./Computer (hours per day): _____

Patient Name: _____

Family History (Please list all relatives of child and check boxes if they have diseases below):

	Age	High Cholesterol	High Triglyceride	Heart Trouble	Obesity	Diabetes	High Blood Pressure	Stroke	Other
Brothers, Sisters									
1.									
2.									
3.									
4.									
Parents									
1.									
2.									
Grandparents									
Mother's side									
1.									
2.									
Father's side									
3.									
4.									
Aunts, Uncles									
Mother's side									
1.									
2.									
3.									
4.									
Father's side									
1.									
2.									
3.									
4.									
Other Relatives									
1.									
2.									

Describe briefly why your child has come to the Lipid Center:
