JACKSON HOSPITAL & CLINIC

Pediatric Hypertension Program
Patient Intake Form

Date_____ Child's Name_____ Date of Birth_____
Relationship to Child (person completing this form)_____
Pediatrician/Primary Care Physician_____
Other specialists involved in the care of your child_____
_____

Birth History

- Gestational age (weeks):_____
- Birth weight:_____
- Pregnancy complications:_____
  _____
  - Any medications during pregnancy?_____
- Pregnancy ultrasound abnormalities:_____
  - Too much (polyhydramnios) or too little (oligohydramnios) amniotic fluid?_____
  - Kidney or bladder abnormalities (ex: hydronephrosis)?_____
  - Congenital heart disease or issues?_____
- Birth complications:_____
  _____
- Did your baby have to stay in the NICU?_____
  - Require umbilical lines/catheters for fluids/medicines?_____
  - Intubated and/or on a breathing machine?_____
  - Any infections in the newborn period?_____
  - Any kidney or urinary issues during the newborn period?_____
  - Any blood pressure problems (high or low) in the NICU?_____
  - Did your baby require diuretic medicines in the NICU?_____

Growth/Development History

- Any issues with short stature or poor linear growth?_____
- Any issues with poor nutrition or poor weight gain?_____
- Any developmental delays in any domains (speech/communication, motor skills, cognitive skills, etc.)?
  _____

Past Medical History

- Has your child ever required hospitalization for any reason?_____
- Has your child every undergone anesthesia or sedation for any reason?_____
  - Any problems during anesthesia?_____
- Any surgeries of any kind?_____
- Any chronic medical conditions or diagnoses?_____
- In the last 3 months, has your child had any acute medical conditions or diagnoses?_____
  _____

- Does your child have any history of kidney or bladder problems?_____
- Any history of congenital heart disease, including coarctation of the aorta?_____
- Ever been diagnosed with a urinary tract infection (UTI)?_____
- Did your child require antibiotics often (>2 times per year) for infections as a young child for ear infections or other infections?_____
- Have you ever been told that your child was overweight, obese, or had a high body mass index (BMI)?
  _____
- Any history of diabetes or prediabetes?_____
- Any history of cholesterol or lipid problems?_____
- History of liver problems?_____
- Vision problems or deficits?_____
- Hearing loss issues or concerns?_____
- Does your child snore loudly or severely?_____
- Has your doctor or you ever wondered if your child has obstructive sleep apnea (OSA)?_____
- Has your child ever been diagnosed with anemia?_____
- Has your child ever been diagnosed with thyroid problems?_____
- Has your child ever had an elevated lead level?_____

Medications

- Does your child take any medications on a regular basis?_____
- Has your child ever been on BP medications?_____
- Does your child have any history of medication allergies?_____
- Does your child take any over-the-counter medications?_____
    - Any supplements, including dietary supplements or weight loss supplements?
      _____
    - Any body building or workout supplements or remedies (ex: creatine, protein shakes)?
      _____
    - Any herbal remedies or homemade remedies (including teas)?
      _____
- Does your child use any form of contraception (ex: birth control pills, depot shots, IUD)?_____
- Does your child take any stimulant or ADHD medications?_____
- Has your child ever used any alcohol or tobacco products?_____
- Has your child ever used any marijuana or illicit drugs?_____
- Has your child every vaped or used electronic cigarettes?_____
- Has your child ever used anabolic steroids?_____

Blood Pressure (BP) History

- At what age do you first recall hearing your child had high BP?_____
- Has your child ever had symptoms that were thought to be related to high BP?_____
- How does your doctor usually measure your child's BP (ex: automated machine or listening with a stethoscope)?_____
- What treatments has your doctor tried for high BP?_____
- Has your child ever had a kidney ultrasound?_____
- Has your child ever had a heart ultrasound (echocardiogram)?_____
- Has your doctor performed any labs in the last year on your child?_____

Nutrition/Diet History

- Would you describe your child's diet as healthy?_____
- Eat a lot of salty foods or foods high in sodium?_____
- Eat a lot of higher fat foods?_____
- Eat fast food regularly?_____
- Consume a variety of fresh fruits and vegetables?_____
- Does your family eat meals together?_____
- Does your child eat homemade meals/foods?_____
- Does your child have any dietary restrictions?_____
- What does your child like to drink?_____
- Does your child eat or drink any caffeinated products (ex: coffee, tea, chocolate, sodas, energy drinks)?
  _____
- Would you consider your child active?_____
- What sort of exercise and/or sports does your child participate in regularly?_____
- Any restrictions currently or in the past on their activity or sports participation?_____

Family History

- Any family members who have a diagnosis of high BP or hypertension?_____
  - What ages were they diagnosed?_____
  - What current medications are they on?_____
  - Any adverse reactions to prior BP medications?_____
- Any family members with a history of stroke or heart attack <60 years old?_____
- Any smokers in the family?_____
- Any known family history of:
  - Chronic kidney disease?_____
  - Protein in the urine?_____
  - Polycystic kidney disease?_____
  - Kidney stones?_____
  - Fibromuscular dysplasia?_____
  - Coronary artery disease?_____
  - Diabetes?_____
  - High cholesterol or high lipid levels?_____
  - Retinal disease?_____
  - Severe vision disorders or deficits?_____
  - Early hearing loss?_____
  - Early or recurrent urinary tract infections?_____
  - Infertility or recurrent miscarriages?_____
  - Bleeding disorders or recurrent blood clots?_____
  - Autoimmune or rheumatologic illnesses?_____

Review of Systems – Check each item that applies.

Does your child currently or have they recently had:

- General:
  - Recent weight loss or gain?
  - Recurrent fevers?
  - Night sweats or daytime sweating for no particular reason?
  - Flushing?
- Eyes:
  - Vision changes?
  - Blurred vision?
  - Eye pain?
  - Sensitivity to light (photophobia)?
  - Excessive dry eyes?
- ENT:
  - Decreased hearing?
  - Recurrent nose bleeds?
  - Recurrent sinus infections?
  - Recurrent oral sores/ulcers?
  - Excessive dry mouth?
  - Trouble swallowing?
- Cardiovascular:
  - Chest pain?
  - Palpitations/heart racing?
  - Swelling in ankles/legs?
  - Shortness of breath with exercise?
- Respiratory:
  - Severe cough?
  - Difficulty breathing?
  - Coughing up blood?
  - Recurrent pneumonia?
- GI:
  - Poor appetite?
  - Recurrent or persistent vomiting?
  - Severe abdominal pain?
  - Yellowing of eyes or skin (jaundice)?
- Genitourinary:
  - Pain with urination?
  - Blood in urine?
  - Dark coffee or cola-colored urine?
  - Significantly frothy or foamy urine?
  - Passage of stones, debris, or sediment in urine?
  - Decreased urine output?
  - Waking up in the night to urinate?
  - Loss of control of urination (incontinence, accidents)?
  - Age of first menstrual cycle?
  - Changes in menstrual cycles?
- Neurologic:
  - Headaches?
  - Seizures?
  - Numbness?
- Musculoskeletal:
  - Joint pain?
  - Joint swelling?
  - Joint stiffness?
  - Muscle weakness?
- Skin:
  - Birthmarks?
  - Rashes when in the sun (photosensitivity)?
  - Color changes?
- Hematologic:
  - Easy bruising or bleeding?
  - Pale or pallor?
- Endocrine:
  - Excessive thirst?
  - Excessive urination?
  - Intolerance to cold temperature?
  - Intolerance to warm temperature?
  - Severe or significant acne?
  - Excessive hair growth?
- Psychiatric:
  - Significant depression?
  - Significant anxiety?
  - Panic attacks?