PEDIATRIC CARDIOLOGY
MEDICAL ASSOCIATES
OF SOUTHERN CALIFORNIA

Timothy W. Casarez, MD., FACC
David A. Ferry, MD., FACC
Nancy Kim, MD., FACC
Frederic Leong, MD., FACC
Jeffrey A. Wong, MD., FACC

FAX COVER LETTER

Welcome to our cardiology practice! In order to save time, please fill out our new patient registration forms and fax them to our office or bring them with you to your child's appointment. For your convenience, you may use this page as the fax cover letter and please do not hesitate to call our office with any questions.

DATE: _____

TO: **PEDIATRIC CARDIOLOGY MEDICAL ASSOCIATES**

FAX #'S: **ENCINO, SANTA CLARITA, LANCASTER:**
Fax (818) 784-1531 • Tel (818) 784-6269

THOUSAND OAKS:
Fax (805) 497-0864 • Tel (805) 497-7214

FROM: _____

PATIENT: _____

TOTAL NUMBER OF PAGES INCLUDING COVER SHEET: _____

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AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

Dear Doctor _____,

We have the pleasure of providing cardiology care to:

Patient: _____ DOB: _____

Please fax copies of the following to (818) 784-1531
or mail to:

PEDIATRIC CARDIOLOGY MEDICAL ASSOCIATES

ENCINO OFFICE
5400 Balboa Blvd, Suite 202
Encino, CA 91316
(818) 784-6269 Fax (818) 784-1531

OR

THOUSAND OAKS OFFICE
555 Marin Street, Suite 220
Thousand Oaks, CA 91360
(805) 497-7214 Fax (805) 497-0864

Patient or guardian name (print): _____

Patient or guardian signature: _____ Date: _____

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FETAL PATIENT HISTORY

Patient's Name: _____ Age: _____

Reason for Referral: _____

OB History:

When was your last menstrual period? _____

When is your due date? _____

Including this one, how many times have you been pregnant? _____

How many living children do you have? _____

Yes No Have you had any miscarriages?
If yes, how many?
Yes No Have you ever terminated a pregnancy?
If yes, how many?
Yes No Have you been treated for infertility?
Yes No Have you had an abnormal AFP test?
Yes No Have you had an abnormal amniocentesis test?
Yes No Have you had an abnormal ultrasound?

Medical History: If yes, please explain.

Yes No Not Sure Do you take any medications?
Yes No Not Sure Do you have allergies to any medications?
Yes No Not Sure Do you have high blood pressure?
Yes No Not Sure Do you have diabetes?
Yes No Not Sure Just during pregnancy?
Yes No Not Sure Diet controlled?
Yes No Not Sure Insulin depedent?
Yes No Not Sure Do you have Lupus (SLE) or another connective tissue disorder?
Yes No Not Sure Do you have anti-Ro or La antibodies?

Social History: If yes, please explain.

Yes No Do you smoke?
Yes No During this pregnancy?
Yes No Do you drink alcohol?
Yes No During this pregnancy?
Yes No Have you used illicit drugs?
Yes No During this pregnancy?

Has anyone in your family had the following? If yes, please explain.

Yes No Child born with a heart problem
Yes No Heart arrhythmia/Pacemaker