PEDIATRIC HYPERTENSION INTAKE (English)

Please fill out completely using dark pen. Mark checkboxes clearly.

PATIENT DEMOGRAPHICS

Patient Name: _____ Date of Birth: _____

Today's Date: _____ Person Filling Out Form: _____

Primary Language: _____ Interpreter Needed? ☐ Yes ☐ No

BLOOD PRESSURE HISTORY

1. How long has blood pressure been elevated?

☐ New / Just found ☐ Months: _____ ☐ Years: _____

2. Do you have a home blood pressure monitor?

☐ No ☐ Yes → Type: ☐ Arm cuff ☐ Wrist cuff

3. Has patient ever taken blood pressure medication?

☐ No ☐ Yes → Name(s): _____

BIRTH & NEONATAL HISTORY

Birth history helps us understand kidney development and blood pressure risk.

☐ Born on time (37+ weeks) ☐ Premature → Born at _____ weeks

☐ NICU stay (Newborn Intensive Care) → How long? _____

☐ Umbilical catheter (IV in belly button)

☐ Small for gestational age / Low birth weight ☐ Adopted / Birth history unknown

☐ Mother had high blood pressure during pregnancy (preeclampsia)

MEDICAL HISTORY

Check all that apply:

☐ History of UTIs (bladder/kidney infections) ☐ Kidney problems

☐ Heart murmur / Heart condition ☐ Known genetic syndrome: _____

☐ Prior echocardiogram (heart ultrasound) ☐ Prior kidney ultrasound

☐ Previously seen cardiologist or nephrologist for blood pressure

Menstrual history (if applicable): ☐ Regular ☐ Irregular ☐ Not yet started ☐ N/A

FAMILY HISTORY (Parents, Siblings, Grandparents)

Condition	Who has this? (e.g., Mom, Dad's father)
☐ High blood pressure (before age 50)	
☐ Heart attack or stroke (before age 55)	
☐ Kidney disease or dialysis	
☐ Sudden unexplained death	
☐ Diabetes (Type 1 or 2)	

CURRENT MEDICATIONS & SUBSTANCES

List ALL current medications, vitamins, and supplements:

Medication Name	Dose/Strength	How often? (e.g., daily, twice daily)

Drug/Food Allergies: _____

Check if patient currently uses any of the following:

☐ ADHD medication (Adderall, Ritalin, Vyvanse, etc.)
☐ Steroids (prednisone, etc.) ☐ Birth control pills
☐ Ibuprofen/Advil/NSAIDs (regular use) ☐ Daily caffeine (coffee, soda)
☐ Energy drinks (Monster, Celsius, Red Bull, etc.)
☐ Tobacco / Vaping / Nicotine ☐ Supplements / Pre-workout / Weight loss products

SLEEP

Sleep Schedule: Typical bedtime: _____ Typical wake time: _____

Does patient have any of the following sleep symptoms?

☐ Snoring ☐ Gasping or pauses in breathing ☐ Daytime sleepiness

Has patient had a sleep study? ☐ No ☐ Yes

If yes: ☐ Sleep apnea diagnosed ☐ Uses CPAP (breathing machine)
☐ Tonsils/adenoids removed

SYMPTOMS (Check if present)

Symptom	No	Yes	If yes, how often?
Headaches	☐	☐	_____
Vision changes / Blurry vision	☐	☐	_____
Chest pain	☐	☐	_____
Racing heartbeat / Palpitations	☐	☐	_____
Flushing (face turns red)	☐	☐	_____
Sweating episodes	☐	☐	_____
Muscle weakness or cramps	☐	☐	_____
Blood in urine	☐	☐	_____
Foamy urine	☐	☐	_____
Swelling (face, hands, legs)	☐	☐	_____
Frequent urination / Excessive thirst	☐	☐	_____
Unintentional weight gain or loss	☐	☐	_____

DIET & NUTRITION (For personalized meal planning)

1. What type of food does your family usually eat? (Check all that apply)

☐ American ☐ Mexican/Latin ☐ Southern ☐ Asian ☐ Indian ☐ Mediterranean
☐ Caribbean ☐ African ☐ Other: _____

2. Food allergies or intolerances: _____

3. Dietary restrictions: ☐ Vegetarian ☐ Vegan ☐ Halal ☐ Kosher ☐ Other: _____

4. Child's FAVORITE foods: _____

5. Foods child will NOT eat: _____

6. What does child typically DRINK? _____

7. Typical SNACKS: _____

8. Meals: Breakfast: ☐ Home ☐ School ☐ Skips Lunch: ☐ Home ☐ School

9. Fast food / Eating out: ☐ Daily ☐ Few times/week ☐ Weekly ☐ Rarely

10. Sugary drinks (soda, juice, sweet tea): ☐ Daily ☐ Few times/week ☐ Rarely

11. Ever seen a dietitian? ☐ No ☐ Yes

Interested in nutrition referral? ☐ Yes ☐ No

EXERCISE & ACTIVITY

1. Overall physical activity level: ☐ Daily ☐ Few times/week ☐ Rarely

2. PE at school? ☐ No ☐ Yes → How often? ☐ Daily ☐ Few times/week

3. Current sports or activities: _____

4. Activities child WANTS to try: _____

5. Physical limitations to exercise? ☐ No ☐ Yes: _____

6. Safe outdoor space (yard, park, neighborhood)? ☐ Yes ☐ No / Limited

7. Access to gym, pool, or exercise equipment? ☐ Yes ☐ No

8. Screen time (TV, phone, gaming): ☐ < 2 hrs/day ☐ 2-4 hrs/day ☐ > 4 hrs/day

HOME & LOGISTICS

1. What city/town/parish do you live in? _____

2. Who else lives in the home? _____

3. After-school situation:

☐ Home (with adult) ☐ Home alone ☐ After-school program ☐ Relative's house

4. Who is in charge of meals and medications at home?

_____

5. Is that person here today? ☐ Yes ☐ No

READINESS FOR CHANGE

On a scale of 1-10, how ready is your family to make healthy changes?

1	2	3	4	5	6	7	8	9	10

Not Ready Ready Now

Have you tried to make healthy changes before? What got in the way?

_____

_____

YOUR QUESTIONS & CONCERNS

What concerns you MOST about your child's blood pressure?

_____

_____

_____

What questions do you have for the doctor today?

_____

_____

_____

ANYTHING ELSE we should know?

_____

_____

_____

OFFICE USE ONLY

Height: _____ Weight: _____ BMI: _____ BP: _____ / _____ HR: _____

Thank you for completing this form. Please return it to the front desk.