

The Lipid Heart Clinic  
The Children's Hospital of Philadelphia  
34<sup>th</sup> Street and Civic Center Boulevard, Philadelphia, PA 19104-4399  
(215) 590-1804 phone; (215) 590-4978 fax  
www.chop.edu/lipidheart

**PATIENT QUESTIONNAIRE**  
PLEASE BRING THIS FORM TO YOUR CLINIC VISIT

Patient Name: \_\_\_\_\_ Home phone: (\_\_\_\_) \_\_\_\_\_  
Parent(s) Name(s): \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_ Email: \_\_\_\_\_  
  
Patient Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

**Physicians:**

**\*Please check box below if you would like  
this physician to receive a letter from us**

***Primary Care Physician:***

Full Name: \_\_\_\_\_ Yes   
Address: \_\_\_\_\_ No   
City, State, Zip Code: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

***Other Physician (specialty):*** \_\_\_\_\_

Full Name: \_\_\_\_\_ Yes   
Address: \_\_\_\_\_ No   
City, State, Zip Code: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

***Other Physician (specialty):*** \_\_\_\_\_

Full Name: \_\_\_\_\_ Yes   
Address: \_\_\_\_\_ No   
City, State, Zip Code: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

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**Personal Census Data**

- You are not required to complete this page. Check here if you do not wish to provide some or all of the information below. If you wish to provide this information, please answer below for your child:

**Ethnicity:**

Do you consider your child to be Hispanic or Latino (See definition below). Please select one:

*Hispanic or Latino.* A person of Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race.

- Hispanic or Latino
- Not Hispanic or Latino
- Unknown

**Race**

What race do you consider your child to be? Select one or more of the following:

- American Indian or Alaska Native.* A person having origins in any of the original peoples of North, Central, or South America, and who maintains tribal affiliation or community attachment.
- Asian.* A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
- Black or African American.* A person having origins in any of the black racial groups of Africa.
- Native Hawaiian or Other Pacific Islander.* A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
- White.* A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- More than one race.* It is preferred that this be selected in addition to the selection of the specific races listed above but also may be solely selected.



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**Family History:**

Please complete the following chart to the best of your knowledge regarding your **child's** family history. Tell us if the family member has the condition. If a family member has had a heart attack, stroke, high blood sugar, high blood pressure or sudden death, please write their age when it happened. We understand that some of this information may not be available.

Relative	Current Age	Highest Cholesterol	Overweight	Heart Attack	Stroke	High Blood Sugar	High Blood Pressure	Sudden Death
Mother								
Mom's Mother								
Mom's Father								
Mom's Siblings								
Father								
Dad's Mother								
Dad's Father								
Dad's Siblings								
Child's Siblings								

Thank you for filling out this form.

Please bring this with you to your child's appointment.

We look forward to seeing you soon.