The Lipid Heart Clinic

Children's Hospital *of* Philadelphia

34th Street and Civic Center Boulevard, Philadelphia PA 19104-4399
(215)- 590- 1804 phone; (267) - 426-9800 fax
www.chop.edu/lipidheart

Dear Parent or Guardian:

Thank you for your interest in the Lipid Heart Clinic at The Children's Hospital of Philadelphia. We take care of children and teenagers who have problems with the levels of cholesterol (or fat) in their blood. These cholesterol problems may put them at risk for heart disease later in life. We are a team of physicians, nurse practitioners, and registered dietitians who work closely with families and their children. We will ask questions about your child's and your family's health, nutrition, and physical activity. We will also do a physical exam on your child. We will help your family make healthy choices and develop a healthy eating plan especially for your child and your family. In some cases we may talk to you about starting medications.

To prepare for this visit, we have included a Patient Questionnaire and diet history. We would like you to fill out these forms and bring them with you to the clinic visit. If this was your child's first lipid panel we would recommend a repeat fasting lipid panel closer to the appointment. **All lipid results are required be faxed (267-426-9800) or emailed (lipidheart@chop.edu) prior to your child's scheduled appointment.** If we do not receive results prior your child's appointment may have to be rescheduled.

While not required, it is helpful to have lipid panel results from biological parents, sisters, and brothers (older than 2 years). The respective primary care provider can order a cholesterol test for each family member if one has never been completed. You can have them done at your local clinic or laboratory. Please either bring a copy of the labs to the child's visit or send to the fax/email above.

Please see next page for location information. If you are unsure which location your child is scheduled please call 215-590-4040. The first visit will last between 1-2 hours, please plan enough time in your day.

Thank you and we look forward to meeting you and your family! Please remember the Patient Questionnaire, diet history, and your family's laboratory studies if completed.

Sincerely,

The Lipid Heart Clinic Team

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The Main hospital location we recommend arriving 20-30 minutes early to your scheduled appointment to allow time for parking, check-in, and vital signs. All other locations we recommend arriving 15 minutes to your scheduled appointment.

Main Campus Philadelphia:
3401 Civic Center Blvd
Main building
3rd Floor Cardiology
Philadelphia PA 19104

Voorhees:
200 Bowman Drive
Health and Wellness Center
2nd Floor Health and Wellness Center
Voorhees NJ 08043

Brandywine Valley:
819 Baltimore Pike
Glen Mills PA 19342

King of Prussia:
550 S Goddard Blvd
King of Prussia PA 19406

Allentown:
1605 N Cedar crest Blvd
Suite 117 & 119
Allentown PA 18104

Lancaster:
2106/2110 Harrisburg Pike
Lancaster PA 17601

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PATIENT QUESTIONNAIRE
PLEASE BRING THIS FORM TO YOUR CLINIC VISIT

Patient Name:______________________ Date of Birth:__________ Age:__________

Home phone: (____) ____________________ Cell phone: (____) ____________________

Address:______________________ Email:______________________

City, State, Zip Code:______________________ Parent(s) Name(s):______________________

Physicians:

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

Full Name:______________________ Yes ☐

Address:______________________ No ☐

City, State, Zip Code:______________________

Phone: (____) __________ Fax: (____) __________

Other Physician (speciality):______________________

Full Name:______________________ Yes ☐

Address:______________________ No ☐

City, State, Zip Code:______________________

Phone: (____) __________ Fax: (____) __________

Other Physician (speciality):______________________

Full Name:______________________ Yes ☐

Address:______________________ No ☐

City, State, Zip Code:______________________

Phone: (____) __________ Fax: (____) __________

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Questions about your child's activity:

Does your child exercise? Yes ☐ No ☐

If yes, what form of activity?____

If No, does your child walk to school or have gym class: ☐ Yes ☐ No

How often?________________ Minutes _____________ times/week

Is your child on a sports team? Yes No

If Yes please specify: ________________

How much time a day does your child spend being active? ________________hours/day

How many hours/day does your child spend on screen time (e.g. watching TV, playing video games, playing on cell phone, and using the computer) that is not homework related?

Weekdays_________________hours per day Weekends__________hours per day

Does your child wear a Fitbit or Activity tracker? Yes ☐ No ☐

If yes, on average how many steps per day? _______________________

Average hours of sleep per night: ____________________________________

Does your child snore: Yes ☐ No ☐

Does your child have any pain or discomfort with exercise? Yes ☐ No ☐

Where is your child able to exercise?

☐ Inside home

☐ Outside the home (e.g. yard, neighborhood, playground)

☐ Gym

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Medications:

Please list current medications: (including prescriptions, vitamins, over-the-counter)

Medication	Dose and how often	Why taking	How long taking

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Family History:

Please complete the follow 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								

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Questions about your child's diet:

To help us evaluate your child's diet, we'd like you to record what your child usually eats on a weekday (school day) and also on a weekend day (non-school day). Use the example below to help you complete your child's usual intake.

Example

Weekday (School day)	Weekend day (Non-school day)
Usual Breakfast 2 frozen waffles with butter and syrup or cold cereal with 2% milk Favorite cereals: Lucky Charms. Cinnamon Toast Crunch, Cheerios Water	**Usual Breakfast** Usually sleeps late so doesn't eat breakfast.
Usual Lunch Buys school lunch most days: Hamburger French fries Piece of fruit Strawberry milk Packs lunch some days: Turkey and cheese sandwich Small bag of chips Piece of fruit Water bottle	**Usual Lunch** Out to lunch many weekends—pizza shop or fast food Hoagie with ham, cheese, and lettuce Potato chips Pepsi OR Chicken nuggets French fries Soda
Usual Dinner Protein with starch and vegetable such as: Baked chicken Mashed potatoes with butter Frozen green beans Capri Sun	**Usual Dinner** Spaghetti with marinara sauce Beef meatballs Salad with lettuce, tomatoes, carrots, croutons and ranch dressing Water
Usual Snacks Usually 2 snacks-after school and after dinner Potato chips or Cheetos after school Ice cream after dinner Sometimes fruit or yogurt	**Usual Snacks** Usually 2-3 snacks on the weekends Salty snacks like chips, Doritos, Fritos
Usual Beverages Water most of the time Milk with school lunch Juice once in awhile	**Usual Beverages** Water most of the time Soda when we go out to eat

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Patient Name: ____

Patient Date of Birth: _______________ Today's Date: __________________

Please record your child's usual intake in the form below.

Weekday (School day)	Weekend day (Non-school day)
Usual Breakfast	**Usual Breakfast**
Usual Lunch	**Usual Lunch**
Usual Dinner	**Usual Dinner**
Usual Snacks	**Usual Snacks**
Usual Beverages	**Usual Beverages**