

Today's Date: _____

Pediatric Cardiac Assessment Form

Patient's Name: _____ DOB: _____

Patient history questions: Please CIRCLE Yes/No for each question below:

1. Has your child fainted or passed out during or after exercise, emotion or startle? **Yes No**
2. Has your child ever had extreme shortness of breath and/or discomfort, pain or pressure in his/her chest during exercise? **Yes No**
3. Has your child had extreme fatigue associated with exercise(different from other children)? **Yes No**
4. Has your doctor ever ordered a test for your child's heart? **Yes No**
5. Has your child ever been diagnosed with an unexplained seizure disorder? Or exercise-induced asthma not well controlled with medication? **Yes No**

Family History Questions: Please tell about any of these in your family. Circle Yes/No.

1. Are there any family members who had sudden unexpected, unexplained death before age 50 (including SIDS, car crash, drowning, others)? **Yes No**
2. Are there any family members who have died suddenly of heart problems before the age of 50? **Yes No**
3. Are there any family members who have had unexpected fainting seizures? **Yes No**
4. Are there any relatives with certain conditions such as:
 - Enlarged heart: HCM **Yes No**
 - Dilated Cardiomyopathy: **Yes No**
 - Heart rhythm problems: LQTS **Yes No**
 - Short QT syndrome: **Yes No**
 - Brugada Syndrome: **Yes No**
 - Catecholaminergic Ventricular Tachycardia: **Yes No**
 - Arrhythmogenic Right Ventricular Cardiomyopathy: **Yes No**
 - Marfan Syndrome (aortic rupture): **Yes No**
 - Heart Attack (age 50 or younger): **Yes No**
 - Pacemaker or Implanted Defibrillator: **Yes No**
 - Deaf at birth (congenital deafness): **Yes No**

Please explain any yes answers here:

Parent Signature _____

Physicians' Signature _____