

PEDIATRIC CARDIAC RISK ASSESSMENT FORM

NAME: _____ D.O.B. _____

I. PATIENT HISTORY QUESTIONS:

Tell me about any of these in your child...

| | Yes | No |
|--|--------------------------|--------------------------|
| Has your child fainted or passed out DURING exercise, emotion or startle? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child fainted or passed out AFTER exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child ever had extreme shortness of breath during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child had extreme fatigue associated with exercise (different from other children?) | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child ever had discomfort, pain or pressure in his chest during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has a doctor ever ordered a test for your child's heart? | <input type="checkbox"/> | <input type="checkbox"/> |
| Has your child ever been diagnosed with an unexplained seizure disorder? Or exercise-induced asthma not well controlled with medication? | <input type="checkbox"/> | <input type="checkbox"/> |

II. FAMILY HISTORY QUESTIONS:

Tell me about any of these in your family...

| | Yes | No |
|---|--------------------------|--------------------------|
| Are there any family members who had a sudden, unexpected, unexplained death before age 50? (Including SIDS, car accident, drowning, others). | <input type="checkbox"/> | <input type="checkbox"/> |
| Are there any family members who died suddenly of "heart problems" before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are there any family members who have had unexplained fainting or seizures? | <input type="checkbox"/> | <input type="checkbox"/> |
| Are there any relatives with certain conditions, such as: | <input type="checkbox"/> | <input type="checkbox"/> |
| Enlarged Heart: Hypertrophic cardiomyopathy (HCM) | <input type="checkbox"/> | <input type="checkbox"/> |
| Dilated cardiomyopathy (DCM) | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Rhythm problems: Long QT syndrome (LQTS) | <input type="checkbox"/> | <input type="checkbox"/> |
| Short QT syndrome | <input type="checkbox"/> | <input type="checkbox"/> |
| Brugada syndrome | <input type="checkbox"/> | <input type="checkbox"/> |
| Catecholaminergic ventricular tachycardia | <input type="checkbox"/> | <input type="checkbox"/> |
| Arrhythmogenic right ventricular cardiomyopathy (ARVC) | <input type="checkbox"/> | <input type="checkbox"/> |
| Marfan syndrome (aortic rupture) | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart attack, age 50 or younger | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker or implanted defibrillator | <input type="checkbox"/> | <input type="checkbox"/> |
| Deaf at birth (congenital deafness) | <input type="checkbox"/> | <input type="checkbox"/> |
| Please explain more about any "yes" answers here: | <input type="checkbox"/> | <input type="checkbox"/> |

PARENT/GUARDIAN SIGNATURE _____ DATE _____

PROVIDER SIGNATURE _____ DATE _____