Pediatric Cardiac Risk Assessment Form

Complete this form for each person under the age of 50, including children, periodically during well child visits including neonatal, preschool, before and during middle school, before and during high school, before college and every few years through adulthood. *If you answer "Yes" or "Unsure" to any questions, read the back of this form.*

Name:_____ **Age:**_____ **Date:**_____

Individual History Questions:	**Yes**	**No**	**Unsure**
Has this person fainted or passed out DURING exercise, emotion or startle?			
Has this person fainted or passed out AFTER exercise?			
Has this person had extreme fatigue associated with exercise (different from others of similar age)?			
Has this person ever had unusual or extreme shortness of breath during exercise?			
Has this person ever had discomfort, pain or pressure in his chest during exercise, or complained of his heart "racing or skipping beats"?			
Has a doctor ever told this person they have: □ high blood pressure □ high cholesterol □ a heart murmur or □ a heart infection? (Check which one, if any.)			
Has a doctor ever ordered a test for this person's heart? If yes, what test and when?			
Has this person ever been diagnosed with an unexplained seizure disorder or exercise-induced asthma? If yes, which one and when?			
Has this person ever been diagnosed with any form of heart/cardiovascular disease? If yes, what was the diagnosis?			
Is this person adopted, or was an egg or sperm donor used for conception?			
Family History Questions (think of grandparents, parents, aunts, uncles, cousins and siblings):			
Are there any family members who had a sudden, unexpected, unexplained death before age 50? (including SIDS, car accident, drowning, passing away in their sleep, or other)			
Are there any family members who died suddenly of "heart problems" before age 50?			
Are there any family members who have had unexplained fainting or seizures?			
Are there any family members who are disabled due to "heart problems" under the age of 50?			
Are there <u>any</u> relatives with certain conditions such as:			
Check the appropriate box: □ Hypertrophic cardiomyopathy (HCM) □ Dilated cardiomyopathy (DCM)			
Check the appropriate box: □ Arrhythmogenic right ventricular cardiomyopathy (ARVC), □ Long QT syndrome (LQTS), □ Short QT syndrome, □ Brugada syndrome, □ Catecholaminergic ventricular tachycardia			
Coronary artery atherosclerotic disease (Heart attack, age 50 years or younger)			
Check the appropriate box: □ Aortic rupture or Marfan syndrome □ Ehlers-Danlos syndrome □ Primary pulmonary hypertension □ Congenital deafness (deaf at birth)			
□ Pacemaker or □ implanted cardiac defibrillator (if yes, whom and at what age was it implanted?)			
Other form of heart/cardiovascular disease or mitochondrial disease			
Has anyone in the family had genetic testing for a heart disease? If yes, for what disease? _____ Was a gene mutation found? Circle one: YES/NO			
Explain more about any "yes" answers here:			

Physician Signature_____ **Patient Name:**_____

Nursing Signature_____ **Date of Birth**_____ **Medic**_____

This form includes all items suggested in the American Heart Association Recommendations for Preparticipation Screening for Cardiovascular Abnormalities in Competitive Athletes– 2007 Update Circulation 2007:115

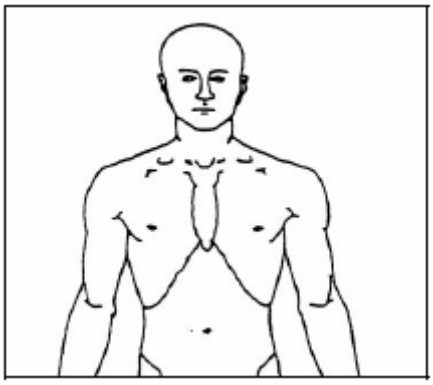
For more information, visit <u>www.choa.org/cardiology</u>, email <u>info@kidsheart.com</u> or call 404-256-2593 (800-542-2233).

Updated 5/8/13 -PCP Initiative

CHEST PAIN QUESTIONNAIRE

NAME:	**(For staff use only)** MRN:
DOB:	DATE

1. **Mark with an X on the diagram below the site of maximal pain, when present.**



2. **The chest pain is described as (Check any/all that apply):**

____ Burning ____ Itching ____ Sharp
____ Dull ache ____ Loss of breath ____ Sticking
____ Fluttering ____ Pressure ____ Other:_____
____ None of the above

3. **How long have you noticed the chest pain to be present?**

____ 48 hours or less ____ 1 – 6 months
____ 2 -7 days ____ More than 6 months
____ 1 week – 1 month ____ Other: _____

4. **How often do you experience the chest pain (Check one)?**

____ Once daily ____ Weekly
____ Several times daily ____ Several times weekly
____ Less often than weekly

5. **The pain usually lasts for (Check one):**

____ Seconds ____ Hours
____ Minutes

6. **Circle a number from 1 – 10 that describes the severity of the chest pain. (1 = least; 10 = worst)**

LEAST **MODERATE** **WORST**
1 2 3 4 5 6 7 8 9 10

CHEST PAIN QUESTIONNAIRE

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7. **Check below when the chest pain occurs:**

____ Rest ____ Both
____ Exercise

8. **Pain is made worse by (Check any that apply):**

____ Exercise ____ Lying down ____ Eating
____ Sitting ____ Coughing ____ Any type of movement
____ Standing ____ Pushing on chest ____ Taking a deep breath
____ None of the above

9. **When you have chest pain, do you also have / suffer from (check all that apply):**

____ Palpitations / irregular heartbeat ____ Nausea
____ Lightheadedness ____ Difficulty breathing
____ Syncope (passing out) ____ Other symptoms: _____
____ None of the above

10. **Have you had any of the following (check all that apply):**

____ Recent chest injury ____ History of asthma
____ Recent cough, wheeze, cold symptoms ____ Kawasaki Disease
____ Recent fever ____ None of the above

11. **Does the chest pain ever wake you from sleep**? □ Yes □ No

12**. Has your child had wheezing or whistling in the chest at any time in the last 12 months?**
□ Yes □ No

13. **Has your child awakened at night because of coughing in the last 12 months?** □ Yes □ No

14. **Has your child had coughing, wheezing, or shortness of breath with exercise or activity and had to stop because of these symptoms at any time in the last 12 months?** □ Yes □ No

15. **When your child has a cold, does the cough usually last more than 10 days?** □ Yes □ No

Order Form

Sibley Heart Center Cardiology
Phone: 404-256-2593 or 800-542-2233
choa.org/cardiology

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Referring Provider: _____

Please ask the patient or parent / guardian to bring this signed form at the time of the visit.

If necessary, generate a referral request from the patient's insurance plan. Please fax the authorization to 404-252-7431.

Patient Name: _____ **Date of Birth:** _____/_____/_____ **Patient Phone:** _____

Provider Name: (please print) _____ **Provider Phone:** _____ **Provider Fax:** _____

Provider Signature: _____ **Date:** _____/_____/_____

Option 1:

_____ **Evaluate and Treat (Patient will see a cardiologist)**

Diagnosis: (Check all that apply)

_____Chest pain
_____Syncope/lightheadedness
_____Palpitations
_____Tachycardia
_____Cardiac Clearance
_____Murmur
_____Cyanotic episodes
_____Hypertension (Need prior BP readings)
_____Hyperlipidemia (Need most recent labs)
_____Abnormal ECG (Need previous ECG)
_____Other _____
(Need appropriate medical records)

-OR-

Option 1:

____ **Test Only (Patient will not see a cardiologist)**
Please indicate diagnosis or reason for test

Reason for Test _____

_____ECG (Need previous ECG if available
_____Echocardiogram
_____Holter Monitor
_____Event Recorder

At Sibley Heart Center Cardiology we have a medical interpreter and language line available to assist all non-English speaking patients.

For a list of our physicians and locations please see other side of this form.

Please call us at 404-256-2593 or visit choa.org/orderpad to request more order pads be sent to your office.

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Scottish Rite hospital
(In Medical Office Building)
Columbus
Cumming
Dalton
Emory-Children's Center
(Located next to Egleston hospital on the Emory University campus)
Gainesville
Hamilton Mill
Macon
Marietta
Newnan
Snellville
Stockbridge
Tifton
Villa Rica

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