PLAYING IT SAFE Cardiac Screening Intake Form

Patient Information:

First Name: MI Last Name:

Date of Birth Month Day Year

Address:

City State Zip

Telephone: Second Phone

Parent/Guardian Name:

Primary Physician: Physician's Address:

Physician's Telephone: Physician's Fax Number:

Patient History:

YES ❑ NO ❑ 1. Has your child fainted or passed out DURING exercise, emotion, or startle?

YES ❑ NO ❑ 2. Has your child fainted or passed out AFTER exercise?

YES ❑ NO ❑ 3. Has your child had extreme fatigue associated with exercise different than other children?

YES ❑ NO ❑ 4. Has your child ever had unusual/extreme shortness of breath during exercise?
If Yes does your child have Asthma? Yes ❑ No ❑

YES ❑ NO ❑ 5. Has your child ever had discomfort, pain, or pressure in his/her chest during exercise or complained of his/her heart "racing" or skipping beats?

YES ❑ NO ❑ 6. Has a doctor ever told you that your child has high blood pressure, high cholesterol, heart murmur, or a heart infection?
(If "yes," check all that apply) ❑ high blood pressure ❑ high cholesterol ❑ heart murmur ❑ heart infection

YES ❑ NO ❑ 7. Has a doctor ever ordered a test for your child's heart?

YES ❑ NO ❑ 8. Has any treatment been necessary?

YES ❑ NO ❑ 9. Has your child ever had any type of heart surgery? If yes please specify procedure done and at what age this occured
_____

YES ❑ NO ❑ 10. Has your child ever been diagnosed with an unexplained seizure disorder or exercise-induced asthma?

Family History Questions:

YES ❑ NO ❑ 1. Have any family members experienced sudden, unexpected death before age 50? (Including sudden infant death syndrome (SIDS), car accident, drowning, and other causes?)

YES ❑ NO ❑ 2. Have any family members died suddenly of "heart problems" before age 50? If yes, with which degree of relative did this occur ❑ Parent ❑ Grandparent ❑ Other - Please specify _____

YES ❑ NO ❑ 3. Have any family members experienced unexplained fainting or seizures?

4. Are there relatives with conditions such as:

YES ❑ NO ❑ Hypertrophic Cardiomyopathy (HCM)

YES ❑ NO ❑ Dilated Cardiomyopathy (DCM)

YES ❑ NO ❑ Aortic rupture of Marfan Syndrome

YES ❑ NO ❑ Coronary artery atherosclerotic disease (heart attack at age 50 or younger)

YES ❑ NO ❑ Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)

YES ❑ NO ❑ Long QT Syndrome (LQTS) or Short QT Syndrome

YES ❑ NO ❑ Brugada Syndrome (Heart rhythm disorder characterized by an abnormal heartbeat called "Brugada")

YES ❑ NO ❑ Catecholaminergic Polymorphic **Ventricular Tachycardia** (CPVT)

YES ❑ NO ❑ Primary pulmonary hypertension (lung hypertension)

YES ❑ NO ❑ Pacemaker or implanted cardiac defibrillator. If yes, with which degree of relative did this occur
❑ Parent ❑ Grandparent ❑ Other - Please specify _____

YES ❑ NO ❑ Congenital deafness (deaf at birth)

*Family and patient history are an important part of screening for cardiac conditions. If you choose not to complete this form, or are otherwise unable to provide complete or accurate answers regarding family or the child's own history, the cardiac screening of your child may not be as thorough as possible. Barnabas Health Outpatient Centers may or may not collect this form at the same time as performing tests today on your child. Even if this form is collected today, Barnabas Health Outpatient Centers shall not be responsible for reviewing the information that you choose to include on this form, but if you do complete this form and provide it to Barnabas Health Outpatients Center today, then the form, and the information you provide, may be shared by Barnabas Health with your child's pediatrician and a referring cardiologist if your child is found to have a cardiac condition which requires further evaluation. Whether or not you provide a completed form today to Barnabas Health, we encourage you to fill out this form as correctly and completely as possible, and discuss the contents of this form with your child's pediatrician, as an additional cardiac screening tool.

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