PLAYING IT SAFE

Cardiac Screening Intake Form

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at Barnabas Health

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?
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 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?
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 Coronary artery atherosclerotic disease (heart attack at age 50 or younger)
   YES ❑ NO ❑ Arrhythmogenic right ventricular cadiomyopathy (ARVC)
   YES ❑ NO ❑ Long QT Syndrome (LQTS)
   YES ❑ NO ❑ Short QT Syndrome
   YES ❑ NO ❑ Brugada Syndrome
   YES ❑ NO ❑ Catecholaminergic polymorphic ventricular tachycardia (CPVT)
   YES ❑ NO ❑ Primary pulmonary hypertension
   YES ❑ NO ❑ Pacemaker or implanted cardiac defibrillator
   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.