Children's Healthcare of Atlanta

Sibley Heart Center CARDIOLOGY

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:			

Physical Exam from Physician should include: (to be performed by a physician – made available here for the purpose of parent/patient education to ensure all evaluations have been completed)			
Evaluation for heart murmur in both supine and standing position and during valsalva			
Femoral pulse			
Brachial artery blood pressure – taken in both arms			
Evaluation for Marfan syndrome stigmata			

Turn form over if you answered "yes" or "unsure" to one or more questions

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 11.21.2011

A Survey From Your Healthcare Provider — PHQ-9 Modified for Teens

TeenScreen® Primary Care

Name_____ Clinician_____

DATE OF BIRTH: _____ Date_____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks? For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

10. In the ***past year*** have you felt depressed or sad most days, even if you felt okay sometimes? ☐ Yes ☐ No

11. If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life? ☐ Yes ☐ No

13. Have you ***ever,*** in your ***whole life,*** tried to kill yourself or made a suicide attempt? ☐ Yes ☐ No

FOR OFFICE USE ONLY **Score**_____

Q. 12 and Q. 13 = Y or TS = ≥11

Source: Patient Health Questionnaire Modified for Teens (PHQ-9) (Author: Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues)

PC-PHQ 9 Mod/6.4.10-1000