Children's Healthcare of Atlanta
*Dedicated to All Better*

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, shoulder, back or jaw during exercise, or complained of their 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 all that apply) | | | |
| 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 any relatives with certain conditions such as:** | | | |
| Check the appropriate box(es): ☐ Hypertrophic cardiomyopathy (HCM) ☐ Dilated cardiomyopathy (DCM) ☐ Arrhythmogenic right ventricular cardiomyopathy (ARVC) ☐ Long QT syndrome (LQTS) ☐ Short QT syndrome ☐ Brugada syndrome ☐ Catecholaminergic polymorphic ventricular tachycardia ☐ Aortic rupture or Marfan syndrome ☐ Ehlers-Danlos syndrome ☐ Primary pulmonary hypertension ☐ Congenital deafness (deaf at birth) | | | |
| Coronary artery atherosclerotic disease (Heart attack, age 50 years or younger) | | | |
| ☐ 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: | Normal | Abnormal |
|---|---|---|
| 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 | | |

Questions shaded in gray represent questions that we believe are of more significance and concern and a referral for cardiac evaluation should be considered

**Person Completing Form:** _____
Print Name

Updated 05.11.17

# East Cobb Pediatrics & Adolescent Medicine, P.C.

Marisa R. Gadea, M.D.
Elizabeth Kemp, M.D.
Karen Thrower, M.D.
Amanda McGahee, M.D.
Padma Iyengar, M.D.
Daniel Heine, M.D.

Tracy Barr, M.D.
Laura Badwan, M.D.
Sharon Lebedin, NP
Barbara Cossman, NP
Shelly Brown, NP


## Georgia Healthy Homes and Lead Poisoning Prevention Program

Patients Name_____ Date of Birth_____

## Risk Factors Assessment Questionnaire

1. Does your child live in or often visit a house that may have been built before 1978?

2. Does your child live in or often visit a house, built before 1978, that is being remodeled or is having paint
removed?

3. Does your child live with or often visit another child that had or has an elevated blood lead level?

4. Does your child live with anyone that works at a job where lead may be found or has a hobby that uses lead?

5. Does your child chew on or eat non-food items like paint chips or dirt?

6. Does your child live near an active lead smelter, battery recycling plant, or other industry likely to release lead?

7. Does your child receive medicines such as greta, azarcon, kohl, or pay-loo-ah?

When using the questionnaire, blood lead tests should be done immediately if the child is at high
risk (one or more "yes" or "I don't know" answers on the risk assessment questionnaire) for lead
exposure.


Marietta: 1121 Johnson Ferry Road, Suite 220, Marietta, GA 30068 ph: 770-977-0094 fax: 770-509-9463
Kennesaw: 6110 Pine Mountain Road, Suite 202, Kennesaw, GA 30152 ph: 770-795-4553 fax: 770-795-4513

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Deanna Fetsch, CPNP
Barbara Cossman, CPNP
Shelly Brown, CPNP

## Parent Instructions for PEDS Form

- This form is a Parent's Evaluation of Developmental Status and helps to ensure that your child is progressing appropriately for their age.
- On the first question, please list any concerns that you have about your child. If you have no concerns, please write that on the form.
- For the remaining questions, answer *yes or A little* if you have the concern now or have had it in the past, even if it has improved. Please comment what the concern is or was.
- Answer No to the following questions if you have never had a concern about that question.
- Once completed, please give this form to the medical assistant or nurse that takes you back to the clinical area. If you have any questions, they will be happy to help you.

Thank you for completing the form.

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To ACCURATELY score PEDS Providers MUST USE Score/Longitudinal Interpretation Forms and Brief Guide to Administration

# PEDS RESPONSE FORM

_____
*Provider*

*Child's Name* _____ *Parent's Name* _____

*Child's Birthday* _____ *Child's Age* _____ *Today's Date* _____

*Please list any concerns about your child's learning, development, and behavior.*

*Do you have any concerns about how your child talks and makes speech sounds?*
*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child understands what you say?*
*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child uses his or her hands and fingers to do things?*
*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child uses his or her arms and legs?*
*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child behaves?*
*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child gets along with others?*
*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child is learning to do things for himself/herself?*
*Circle one: No Yes A little COMMENTS:*

*Do you have any concerns about how your child is learning preschool or school skills?*
*Circle one: No Yes A little COMMENTS:*

*Please list any other concerns.*



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# M-CHAT

www.m-chat.org

Child's name _____ Date _____

Age _____ Relationship to child _____

**M-CHAT-R™** *(Modified Checklist for Autism in Toddlers Revised)*

Please answer these questions about your child. Keep in mind how your child usually behaves. If you have seen your child do the behavior a few times, but he or she does not usually do it, then please answer **no**. Please circle **yes** or **no** for every question. Thank you very much.

| | | |
|---|---|---|
| 1. If you point at something across the room, does your child look at it? (**FOR EXAMPLE**, if you point at a toy or an animal, does your child look at the toy or animal?) | Yes | No |
| 2. Have you ever wondered if your child might be deaf? | Yes | No |
| 3. Does your child play pretend or make-believe? (**FOR EXAMPLE**, pretend to drink from an empty cup, pretend to talk on a phone, or pretend to feed a doll or stuffed animal?) | Yes | No |
| 4. Does your child like climbing on things? (**FOR EXAMPLE**, furniture, playground equipment, or stairs) | Yes | No |
| 5. Does your child make unusual finger movements near his or her eyes? (**FOR EXAMPLE**, does your child wiggle his or her fingers close to his or her eyes?) | Yes | No |
| 6. Does your child point with one finger to ask for something or to get help? (**FOR EXAMPLE**, pointing to a snack or toy that is out of reach) | Yes | No |
| 7. Does your child point with one finger to show you something interesting? (**FOR EXAMPLE**, pointing to an airplane in the sky or a big truck in the road) | Yes | No |
| 8. Is your child interested in other children? (**FOR EXAMPLE**, does your child watch other children, smile at them, or go to them?) | Yes | No |
| 9. Does your child show you things by bringing them to you or holding them up for you to see – not to get help, but just to share? (**FOR EXAMPLE**, showing you a flower, a stuffed animal, or a toy truck) | Yes | No |
| 10. Does your child respond when you call his or her name? (**FOR EXAMPLE**, does he or she look up, talk or babble, or stop what he or she is doing when you call his or her name?) | Yes | No |
| 11. When you smile at your child, does he or she smile back at you? | Yes | No |
| 12. Does your child get upset by everyday noises? (**FOR EXAMPLE**, does your child scream or cry to noise such as a vacuum cleaner or loud music?) | Yes | No |
| 13. Does your child walk? | Yes | No |
| 14. Does your child look you in the eye when you are talking to him or her, playing with him or her, or dressing him or her? | Yes | No |
| 15. Does your child try to copy what you do? (**FOR EXAMPLE**, wave bye-bye, clap, or make a funny noise when you do) | Yes | No |
| 16. If you turn your head to look at something, does your child look around to see what you are looking at? | Yes | No |
| 17. Does your child try to get you to watch him or her? (**FOR EXAMPLE**, does your child look at you for praise, or say "look" or "watch me"?) | Yes | No |
| 18. Does your child understand when you tell him or her to do something? (**FOR EXAMPLE**, if you don't point, can your child understand "put the book on the chair" or "bring me the blanket"?) | Yes | No |
| 19. If something new happens, does your child look at your face to see how you feel about it? (**FOR EXAMPLE**, if he or she hears a strange or funny noise, or sees a new toy, will he or she look at your face?) | Yes | No |
| 20. Does your child like movement activities? (**FOR EXAMPLE**, being swung or bounced on your knee) | Yes | No |

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