Youth Heart Screening Form

Parent Phone # (___) _____ Height _____(ft/in) Weight _____(pounds)

Primary Physician_____ Physician Phone # (___) _____

PARENT or GUARDIAN Please Complete Medical History Questionnaire

FAMILY HISTORY: (*check all that apply for immediate relatives with history of the following)*

- ☐ Premature death related to heart disease before age 50 (#8)
- ☐ Disability from heart disease before age 50 (#9)
- ☐ Hypertrophic or Dilated Cardiomyopathy (#10a)
- ☐ Long-QT Syndrome or other ion channelopathies (#10b)
- ☐ Arrhythmias (#10d)
- ☐ Marfan Syndrome (#10c)
- ☐ Genetic Cardiac Condition (#10e)

PERSONAL HISTORY:

1. Does the participant have chest pain, chest discomfort, tightness or pressure? When? (exertion, resting, anytime)	☐ YES ☐ NO
2. Does the participant become lightheaded, dizzy or pass out/faint (syncope or near syncope)? When? (exertion, resting, anytime)	☐ YES ☐ NO
3a. Does the participant experience shortness of breath or wheezing with activity or exercise?	☐ YES ☐ NO
3b. Does the participant become tired or fatigued more quickly than usual with activity or exercise?	☐ YES ☐ NO
3c. Does the participant experience skipped heartbeats or palpitations with activity or exercise?	☐ YES ☐ NO
4. Has the participant been told he or she has a heart murmur or heart disease?	☐ YES ☐ NO
5. Does the participant have elevated or high blood pressure?	☐ YES ☐ NO
6. Has the participant been told in the past that he or she cannot participate in sports?	☐ YES ☐ NO
7. Has the participant been tested by a physician for a heart condition?	☐ YES ☐ NO

PHYSICAL EXAM: The American Heart Association recommends an additional 4 element physical examination for pre participation screening in competitive athletics. The Youth Heart Screening DOES NOT provide clearance for participation in athletics, it is a supplement to pre participation athletic screening targeted for causes of Sudden Cardiac Arrest (SCA).

Parent / Guardian Signature: _____ **Date:** _____

This section to be completed by the **CARDIOLOGIST** *or* **SONOGRAPHER** *after screening*

Blood Pressure:_____mmHg LVPWd:_____cm IVSd:_____cm

Coronary Arteries: ☐ Normal origin ☐ Unusual origin ☐ Unable to visualize origin

Action Plan

- ☐ **NO ABNORMAL FINDINGS:** Continue to follow-up with your primary care physician.
- ☐ **Normal Variant Noted:** Routine follow-up with a Pediatrician advised.
- ☐ **Incidental Finding:** Follow-up with a Pediatric Cardiologist advised.
- ☐ **ABNORMAL FINDING: Avoid athletic activity and follow-up with a Pediatric Cardiologist.**

☐ **Echocardiogram:**

☐ **Heart Rhythm Evaluation (EKG):**

☐ **Heart Rate:**

☐ **Blood Pressure:**

Physician Signature: _____ **Dictation #:** _____ **Date:** _____

THE HEART HOSPITAL BAYLOR PLANO
THE HEART HOSPITAL BAYLOR DENTON