



Box Hill Pediatrics

39 Kensington Parkway
Abingdon, MD 21009

Phone 410-569-7337 / Fax 410-569-7347

info@boxhillpediatrics.com

http://www.boxhillpediatrics.com

Heart Disease Risk Assessment

Child's Name: _____

| Number | Question | Answer |
|--------|--|--------|
| 1 | Please answer the following questions to help assess your child's risk of heart problems | Y N |
| 2 | Has your child ever been diagnosed with a heart defect or heart disease? | Y N |
| 3 | Has your child ever had a seizure or fainted? | Y N |
| 4 | Has your child ever noticed chest pain, dizziness or breathing problems with exercise? | Y N |
| 5 | Has your child ever noticed palpitations (unexplained increase in heart rate or skipped beat)? | Y N |
| 6 | Has your child ever been diagnosed with a heart murmur? | Y N |
| 7 | Has your child ever been noted to have high blood pressure? | Y N |
| 8 | Does your child take any medications? | Y N |
| 9 | Does your child use any supplements? | Y N |
| 10 | Does your child use caffeine in sodas or energy drinks? | Y N |
| 11 | Does your child smoke cigarettes? | Y N |
| 12 | Has any relative of the child died unexpectedly before the age of 35? | Y N |
| 13 | Has any relative of the child had a heart attack or stroke before the age of 55? | Y N |
| 14 | Has any relative of the child had a pace maker or heart rhythm abnormality? | Y N |
| 15 | Has any relative of the child been diagnosed with congestive heart failure? | Y N |
| 16 | Has the child or a family member been diagnosed with Marfan Syndrome? | Y N |

Please list any other details you think your pediatrician should know about your child's health:

Signature: _____ Date: _____

klh 4/08