# CHILD HEALTH CARE ASSOCIATES

Name_____DOB_____

**CARDIAC ASSESSMENT:**

1) Have you ever fainted, passed out, or had a seizure during or after exercising?

No_____ Yes_____ Please explain_____

2) Have you ever experienced severe chest pain while exercising?

No_____ Yes _____ Please explain_____

3) Are you related to anyone who died suddenly from heart problems or cardiac arrest before the age of 50?

No_____ Yes _____ Please explain _____

4) Are you related to anyone with hypertrophic cardiomyopathy, dilated cardiomyopathy, Brugada Syndrome, Cardiac arrhythmia's or prolonged Qt Syndrome?

No _____ Yes _____ Please explain_____

_____ _____

Parent signature (or patient signature if 18 yrs or older) Date