

Pectus Patient Evaluation

*Please take a few minutes to complete the following questions so we may better serve your child.
Please type or print.*

Date completed: _____

Patient's full name _____

Parent's name _____

1. What is the main reason you are seeking medical/surgical evaluation for your child?

2. Is your child's Pectus Excavatum (depression) getting worse? Check one: Yes No

Or Pectus Carinatum (protrusion) getting worse? Check one: Yes No

3. If you answered yes to question 2, over what amount of time have you noticed your child's condition worsen?

Check one: Over about six months One year Five years

4. How old was your child when you noticed the depression? _____

Or protrusion? _____

5. What other symptoms have you noticed or has your child complained of? Please check all that apply:

Exercise intolerance, i.e., inability to play for prolonged times out of doors or during strenuous activities like sports; inability to keep up with other children of the same age during active play.

Explain: _____

Lack of endurance, i.e. needs to stop for rest or to catch their breath during strenuous activity; unable to continue while others of the same age can.

Explain: _____

- | | |
|---|---|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Chest pain only when exercising |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Shortness of breath only when exercising |
| <input type="checkbox"/> Need to change or modify physical activity | <input type="checkbox"/> Frequent respiratory tract infections |
| <input type="checkbox"/> Prolonged respiratory tract infections | <input type="checkbox"/> Asthma or asthma like symptoms |
| <input type="checkbox"/> Palpitations (i.e., irregular heart beating) | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Other? Explain _____ | |

6. Is your child: Adopted? Ward of the state?

7. Does your child have an identical twin? Yes No

8. If so, does your child's identical twin have pectus excavatum? Yes No

Or pectus carinatum? Yes No

9. Do others in your family, including extended family, have pectus excavatum? Yes No

If yes, please explain the family relationship: _____

10. Do others in your family, including extended family, have pectus carinatum? Yes No

If yes, please explain the family relationship: _____

11. Is there a family history of: Marfan's syndrome? Yes No Ehlers-Danlos syndrome? Yes No

12. Is your child allergic to metal? Yes No

If yes, please explain: _____

(Examples: skin irritation with jewelry, skin irritation with buttons from clothing, etc)

13. Is there a direct family member that has an allergy to metal? Yes No

14. Has your child had x-rays taken? Yes No

If yes, please send copies of those studies and scans.

15. Has your child had a cardiology (heart) evaluation? Yes No

If yes, please send copies of those reports.

16. Has your child had pulmonary function (lung) studies? Yes No

If yes, please send copies of those reports.

17. Has your child ever had bracing therapy? Yes No

If yes, please complete below:

How long has your child been receiving therapy? _____

Have you noticed any changes with the use of the brace? _____