

# *Pectus Carinatum 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 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 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 _____                         |   |

*Please complete reverse side.*

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:* \_\_\_\_\_

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(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? \_\_\_\_\_