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: ____________________________________________________________________________

□ Chest pain
□ Shortness of breath
□ Need to change or modify physical activity
□ Prolonged respiratory tract infections
□ Palpitations (i.e., irregular heart beating)
□ Other? Explain ________________________________________________________________

□ Chest pain only when exercising
□ Shortness of breath only when exercising
□ Frequent respiratory tract infections
□ Asthma or asthma like symptoms
□ Scoliosis

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:    _____________________________________________________________

   (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? _________________________________