Pectus Excavatum 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

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 first noticed the depression? ______________________

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 the 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.