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: ____________________________________________________________

□ 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
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? __________________________

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