Dr. R. G. Beaulieu, M.D., F.R.C.P. (C)

CHEST PAIN QUESTIONNIARE

Date:

PATIENT NAME: _____

Please fill out this questionnaire, either mail or fax it back to our office.

Does your child complain of ….

- Palpitations
- Dizziness/Syncope
- Shortness of breath

1. What was your child doing when episode of chest pain occurred?
   a. Was it at rest (i.e. watching TV) if so, explain

   b. Was it with exercise related activity (i.e. gym), if so, explain.

      i. Is your child involved in any competitive sports? ☐ No ☐ Yes, explain

2. How frequent are the chest pain episodes? How long does the chest pain last?

3. Describe what the chest pain feels like?

   ☐Sharp stabbing ☐Crushing ☐Aching ☐Tightness ☐Pressure Like ☐Other_____

4. Where does the chest pain occur? ☐ left sided ☐ right sided ☐ middle chest

5. Does chest pain ever awaken your child at night time? ☐ No ☐ Yes, explain_____

6. How would you rate your chest pain on the scale of 1 to 10, with 10 as the most severe?
   1------2------3------4------5------6------7------8------9------10

7. Is chest pain related to trauma? ☐ No ☐ Yes, explain_____

8. What makes the chest pain go away?

   ☐ Resting ☐Sleeping ☐Eating ☐Medication, Name_____ ☐Other_____

9. Does your child experience pain elsewhere in the body? ☐ No ☐ Yes, explain_____

10. Does the chest pain affect your child's normal activities? ☐ No ☐ Yes, explain_____

11. Does child have asthma or any other illness? ☐ No ☐ Yes, explain_____

12. Are there any Family histories of Heart Defects? ☐ No ☐ Yes, explain_____

13. Was your child sick recently with the flu? ☐ No ☐ Yes, explain_____

14. Is your child on any medications? ☐ No ☐ Yes, explain_____

15. Description of recent/past episodes.

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