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

PALPITATIONS QUESTIONNIARE

Does your child complain of ….

- Chest Pain
- Dizziness/Syncope
- Shortness of breath

Date: **PATIENT NAME:** _____

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

1. Describe your child's palpitations
   a. Pounding b. Jumping c. Fluttering, flip-flopping

2. Does your child have a feeling of missed or skipped beats? ☐ No ☐ Yes, explain_____

3. What was your child doing when episode of palpitation 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

4. How frequent are the episodes? How long does the episode last?

5. When do the episodes occur?
   a. Morning ☐ No ☐ Yes
   b. Afternoon ☐ No ☐ Yes
   c. Night ☐ No ☐ Yes if so, does the palpitation ever awaken your child at night time? ☐ No ☐ Yes,

6. Is the palpitation related to trauma? ☐ No ☐ Yes, explain_____

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

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

9. What makes the palpitation go away?
   ☐ Resting ☐ Sleeping ☐ Eating ☐ Medication, Name_____ ☐ Other_____

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

11. Does the palpitation affect your child's normal activities? ☐ No ☐ Yes, explain_____

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

13. Does your child smoke? ☐ No ☐ Yes

14. Does your child drink caffeinated beverages (i.e pop, hot chocolate, coffee, tea)? ☐ No ☐ Yes

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

16. Description of recent/past episodes.

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