

COMMACK PUBLIC SCHOOLS
COMMACK, NEW YORK
Cardiac History Form

MANDATORY for all students entering grades 7 and 9 and for any 1st time athletes

Student's Name _____ Date of Birth _____ Age _____

Address _____

Home Phone _____ Cell Phone _____ Male _____ Female _____

Parent's/Guardian's Name _____

Name, Address and Phone Number of Primary Care Physician/Pediatrician: _____

1. Has your child ever had chest pain or discomfort? If yes, please describe YES NO

2. Has your child ever passed out or almost passed out? If yes, please describe YES NO

3. Has your child ever been short of breath or experienced fatigue with exercise? If yes, please describe YES NO

4. Has your child ever been told he/she has a heart murmur? If yes, please describe YES NO

5. Has your child ever had high blood pressure? If yes, please describe YES NO

6. Has anyone in your family died before the age of 50? If yes, please describe YES NO

7. Has anyone in your family died before the age of 50 due to heart disease? If yes, please describe YES NO

8. Do you know of any relatives less than 50 that are disabled with heart disease? If yes, please describe YES NO

9. Do you know of any family members with the following heart diseases: Cardiomyopathy, Long-qt Syndrome, Marfan Syndrome, Arrhythmogenic Right Ventricular Dysplasia, Anomalous Coronary Artery, Catecholmanigeric Polymorphic Ventricular, Arrythmias Tachycardia (CPVT)? If yes, please describe YES NO (Please circle any applicable)

10. Is your child currently on any medication? If yes, please describe YES NO

Name of person completing form: _____ Relationship to Child _____

Signature: _____ Date/Time _____

Form Reviewed by (Commack UFSD) _____
Name Signature Date

FOR PHYSICIAN USE ONLY:

1.Heart Murmur YES NO 2.Marfan Syndrome Physical Stigmata YES NO Brachial Artery Blood Pressure (sitting position) _____

Physician's Signature: _____ Date Time _____