PEDIATRIC SYNCOPE / NEAR-SYNCOPE INTAKE

Please complete all sections. Use dark ink. Write "don't know" if unsure.

Patient Name: _____ **DOB:** _____ **Date:** _____

Form completed by: _____ **Relationship:** _____

THE EVENT(S)

How many fainting or near-fainting episodes has your child had?

[ ] 1 [ ] 2-3 [ ] 4-10 [ ] More than 10

When did the **FIRST** episode occur? _____ When did the **MOST RECENT**? _____

What **TIME OF DAY** do episodes usually happen?

[ ] Morning [ ] Afternoon [ ] Evening [ ] No pattern [ ] Only had one

FOR THE MOST RECENT (OR MOST CONCERNING) EPISODE:

What **POSITION** was your child in when symptoms started?

[ ] Standing [ ] Sitting [ ] Lying down [ ] Don't know

What was your child doing **RIGHT BEFORE** the episode? (check all that apply)

[ ] Standing still for a while

[ ] Exercising / playing sports

[ ] Just finished exercising (within 5-10 min)

[ ] Getting up from sitting or lying

[ ] Sudden loud noise or startle

[ ] In a hot environment / shower

[ ] Having blood drawn / seeing blood

[ ] Straining (coughing, urinating, BM)

[ ] Emotional stress / pain / fear

[ ] Other: _____

Did your child **LOSE CONSCIOUSNESS** (pass out completely)?

[ ] Yes, completely [ ] No, felt like might but didn't [ ] Unsure

If passed out, for **HOW LONG**?

[ ] Less than 30 sec [ ] 30 sec - 1 min [ ] 1-5 min [ ] More than 5 min [ ] Don't know

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WARNING SYMPTOMS — Before the Episode

Did your child have **ANY warning** before the episode?

[ ] Yes, had warning symptoms [ ] No, it came on suddenly with no warning

If YES, which warning symptoms? (check all that apply)

[ ] Lightheadedness / dizziness	[ ] Nausea	[ ] Vision changes (tunnel, spots)
[ ] Sweating	[ ] Feeling hot / flushed	[ ] Hearing changes (muffled, ringing)
[ ] Heart racing / pounding	[ ] Chest pain or pressure	[ ] Shortness of breath
[ ] Headache	[ ] Numbness / tingling	[ ] Room spinning (vertigo)

WHAT WITNESSES SAW

Was anyone there who **SAW** the episode?

[ ] Yes [ ] No (child was alone)

If YES, what did they observe? (check all that apply)

[ ] Went pale / lost color	[ ] Eyes rolled back	[ ] Fell down
[ ] Stiffening of body	[ ] Shaking / jerking movements	[ ] Bit tongue or cheek
[ ] Lost bladder control	[ ] Made sounds / cried out	[ ] Turned blue

RECOVERY — After the Episode

How quickly did your child **return to normal**?

[ ] Immediately (< 1 min) [ ] 1-5 minutes [ ] 5-30 minutes [ ] More than 30 min

After the episode, was your child: (check all that apply)

[ ] Alert and oriented right away	[ ] Confused for a while	[ ] Sleepy / tired for hours
[ ] Had a headache	[ ] Sore muscles	[ ] No memory of what happened

Was your child **INJURED** during the episode?

[ ] No injury [ ] Minor (bruise, scrape) [ ] Serious: _____

!! IMPORTANT — RED FLAG SYMPTOMS

These help identify serious causes. Please answer carefully.

Has your child EVER fainted DURING exercise (while actively running, playing)?	[ ] Yes [ ] No
Has your child EVER had chest pain or palpitations RIGHT BEFORE fainting?	[ ] Yes [ ] No
Has your child EVER fainted while lying down or sitting still?	[ ] Yes [ ] No
Has your child EVER fainted while swimming or in water?	[ ] Yes [ ] No
Has your child EVER fainted after a sudden loud noise or startle?	[ ] Yes [ ] No

PEDIATRIC SYNCOPE / NEAR-SYNCOPE INTAKE

MEDICAL HISTORY

Has your child been diagnosed with any of these?

[ ] Heart murmur
[ ] Heart condition: _____
[ ] Hearing loss or deafness
[ ] Concussion / head injury
[ ] Seizure disorder
[ ] Anemia
[ ] Diabetes
[ ] Thyroid problems
[ ] Anxiety or panic attacks
[ ] Eating disorder
[ ] Migraine headaches

Has your child ever had an abnormal EKG, echo, or heart monitor?

[ ] No [ ] Never tested [ ] Yes — describe: _____

PRIOR WORKUP — Tests Already Done

Check all tests that have **already been completed**:

[ ] EKG
[ ] Tilt table test
[ ] Blood work (CBC, glucose, etc.)
[ ] Echocardiogram (heart ultrasound)
[ ] EEG (brain wave test)
[ ] None of the above
[ ] Holter or event monitor
[ ] MRI of brain or heart

If any were **abnormal**, describe: _____

SYMPTOMS WITH STANDING — Dysautonomia Screening

Does your child regularly experience any of these?

[ ] Lightheaded when standing up
[ ] Exercise intolerance (tires easily)
[ ] Fatigue / low energy
[ ] Nausea or stomach upset
[ ] Brain fog / trouble concentrating
[ ] Frequent headaches

MEDICATIONS & SUBSTANCES

Is your child currently taking any of these?

[ ] ADHD medication (Adderall, Vyvanse, etc.)
[ ] Blood pressure medication
[ ] Birth control pills
[ ] Antidepressant or anti-anxiety
[ ] Allergy medication (antihistamines)
[ ] Asthma medication

Other medications: _____

How many times per week does your child use: (write number, or 0 if never)

Energy drinks: ____ /wk
Pre-workout / supplements: ____ /wk
Caffeine (coffee, soda): ____ /wk
Nicotine / vaping: ____ /wk

Has your child had any **illness in the past 4 weeks**?

[ ] No [ ] Yes — describe: _____

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LIFESTYLE & ACTIVITY

Water/fluids per day: [ ] < 2 cups [ ] 2-4 cups [ ] 4-6 cups [ ] 6+ cups [ ] Don't know

Eats breakfast: [ ] Most days [ ] Sometimes [ ] Rarely/never

Sleep on school nights: _____ hours

SPORTS & ACTIVITY

Does your child participate in organized sports?

[ ] No [ ] Yes — Sport(s): _____

Level: [ ] Recreational [ ] School team [ ] Travel / club / competitive

Is your child currently cleared for sports?

[ ] Yes [ ] No, was restricted [ ] Not applicable

FOR FEMALES ONLY — Menstrual History (skip if not applicable)

Has your daughter started her period?	[ ] Yes	[ ] No
If yes: Are periods heavy?	[ ] Yes	[ ] No
Do episodes happen around her period?	[ ] Yes	[ ] No

!! FAMILY HISTORY — Critical Information

Parents, siblings, grandparents, aunts, uncles. These questions are very important.

[ ] Died suddenly and unexpectedly before age 50	Who? _____
[ ] Drowned or had an unexplained drowning	Who? _____
[ ] Diagnosed with a heart rhythm problem	Who? _____
[ ] Has a pacemaker or defibrillator (ICD)	Who? _____
[ ] Told they have "Long QT syndrome"	Who? _____
[ ] Told they have cardiomyopathy (thick/enlarged heart)	Who? _____
[ ] Fainted during exercise or with sudden loud noises	Who? _____
[ ] Born deaf or have significant hearing loss	Who? _____
[ ] Had seizures	Who? _____

YOUR QUESTIONS & CONCERNS

What concerns you **MOST** about these episodes? _____

What questions do you have for the doctor today? _____

OFFICE USE ONLY

Height:	_____	**Weight:**	_____	**BP supine:**	____/____	**HR supine:**	_____
Tanner:	_____	**ECG:**	_____	**BP standing:**	____/____	**HR standing:**	_____

Thank you for completing this form. Please return to the front desk.