Hunterdon Pediatric Associates
Medication Monitoring Questionnaire for Parents / Patients

Patient's Name_____
Patient's Date of Birth _____
Today's Date_____

Family History – (parent, grandparent, aunt, uncle, sibling of the person treated with the medication)
Circle Yes or No

Yes **No** Sudden cardiac death or "heart attack" in relatives younger than 35 years of age
Yes **No** Sudden cardiac death during exercise
Yes **No** Cardiac arrhythmias (abnormal heart rhythm)
Yes **No** Hypertrophic cardiomyopathy (HCM) or other cardiomyopathy (inflamed heart muscle)
Yes **No** Long QT syndrome (LQTS) or short QT syndrome
Yes **No** Brugada's syndrome
Yes **No** Wolff-Parkinson White (WPW) syndrome
Yes **No** Marfan syndrome
Yes **No** Fainting requiring resuscitation (CPR) before age 35

Please explain any yes responses: _____

_____

Personal History – (for the person treated with the medication)
Circle Yes or No

Yes **No** Fainting or dizziness, particularly with exercise
Yes **No** Seizures
Yes **No** Exercise-induced chest pain or shortness of breath
Yes **No** Unexplained change in exercise tolerance
Yes **No** Palpitations, rapid heart rate or extra/skipped beats
Yes **No** History of a viral illness with chest pain or palpitations
Yes **No** Trouble sleeping
Yes **No** Abdominal pain
Yes **No** Headaches
Yes **No** Mood changes, increased anxiety, increased restlessness on the medication
Yes **No** Rebound symptoms when stimulant wears off

Please explain any yes responses: _____