CARDIAC SCREENING QUESTIONNAIRE

PLEASE COMPLETE THE FOLLOWING INFORMATION THAT APPEARS BELOW. DO NOT COMPLETE THE SECTION MARKED FOR PHYSICIAN USE ONLY.

Student's Name ____________________________
Address ____________________________________________________________
Home Phone ___________ Cell Phone ________________
Date of Birth ___________ Age _______ Grade ______ Gender: M or F School ___________ Sport ___________
Name/Address of Primary care Physician/Pediatrician ______________________________

Phone Number of Primary care Physician/Pediatrician _______________________
Parent/Guardian's Name ____________________________
Parent/Guardian's Address (if different from above) ______________________________

Answer the following questions to the best of your ability. Please note if you are a parent or other legal guardian completing this form, the "You" refers to your child.

1. Have you ever had chest pain or discomfort? ☐ Yes ☐ No If yes, please describe ______________________________

2. Have you ever passed out or almost passed out? ☐ Yes ☐ No If yes, please describe ______________________________

3. Have you ever been short of breath or very fatigued with exercise? ☐ Yes ☐ No If yes, please describe ______________________________

4. Have you ever been told that you have a heart murmur? ☐ Yes ☐ No If yes, please describe ______________________________

5. Have you ever had high blood pressure? ☐ Yes ☐ No If yes, please describe ______________________________

6. Has anyone in your family died before age 50 due to heart disease? ☐ Yes ☐ No If yes, please describe ______________________________

7. Do you know of any close relatives less than 50 years old that are disabled with heart disease? ☐ Yes ☐ No If yes, please describe ______________________________

8. Do you know of any family members with the following heart diseases: Cardiomyopathy, Long-qt Syndrome, Marfan Syndrome, Arrhythmias? ☐ Yes ☐ No If yes, please describe ______________________________

9. Are you currently on any medication? ☐ Yes ☐ No If yes, please describe ______________________________

Name: ____________________________ Relationship to Patient: ____________________________ Date/Time: ___________

Reviewed by: ____________________________

FOR PHYSICIAN USE ONLY:

1. Appropriate consent obtained and on hand? ☐ Yes ☐ No 3. Femoral pulses – Aortic Coarctation ☐ Yes ☐ No
2. Heart Murmur ☐ Yes ☐ No 4. Marfan Syndrome Physical Stigmata ☐ Yes ☐ No
Blood Pressure ___________ Pulse ___________ EKG ___________ Echo ___________
Physician Signature: ____________________________ Date/Time: ___________ ID #: ___________