Sudden Cardiac Death Prevention Screening

SCREENING America
On a Mission to Save Lives

Please fill out this **Health History**, the **Marfan questionnaire**, sign the **Consent form**. Bring all three with you to your appointment. Thanks!

Name:_____ **M:**____ **F:**____ **Age:**_____ **Date of Birth:** ___/___/_____
Ethnicity: __ American Indian __ Asian __ Black/African American __ Latino/Hispanic __ White/Caucasian
Grade: _____ **School:** _____ **Ht:** _____**Wt:** _____**Activities:** _____
Address/City/State/Zip: _____
Parent/Guardian Name(if patient is a minor): _____ **Relationship:** _____
Parent Phone: _____ **Screening Location:** _____ **Doctor:** _____

Please circle questions if you don't know the answers. Give brief explanation for any YES answers.

HEALTH HISTORY	YES	NO
1. Have you ever passed out or fainted during or after exercise?	☐	☐
2. Have you ever been dizzy during or after exercise?	☐	☐
3. Have you ever had chest pain during or after exercise?	☐	☐
4. Do you seem to tire more easily than others doing the same activity?	☐	☐
5. Have you ever felt your heart racing or felt it skipped a beat?	☐	☐
6. Have you had high blood pressure or high cholesterol?	☐	☐
7. Have you ever been told you have a heart murmur?	☐	☐
8. Any family history of cardiac death before age 50?	☐	☐
9. Have you had a severe viral infection within the past month?	☐	☐
10. Have you ever been diagnosed with heart problems?	☐	☐
11. Do you have a family history of heart disease?	☐	☐
12. Do you cough, wheeze or have trouble breathing during or after activity?	☐	☐
13. Do you have asthma? If YES, do you use an inhaler? Type _____	☐	☐
14. Do you have seasonal allergies that require medical treatment?	☐	☐
15. Have you had a medical illness or injury since your last sports physical?	☐	☐
16. Are you taking any prescription or over the counter medications?	☐	☐
17. Do you have any other allergies, i.e. pollen, food, medicine or bees?	☐	☐
18. Do you use tobacco products?	☐	☐
19. Do you consume alcoholic beverages?	☐	☐
20. Do you consume caffeine daily?	☐	☐
21. Do you have an eating disorder i.e. anorexia or bulimia?	☐	☐
22. Do you have persistent headaches, visual changes or frequent dizziness?	☐	☐
23. Do you use muscle enhancing substances?	☐	☐
24. Have you been diagnosed with Marfan's Syndrome?	☐	☐
25. Have you ever previously been restricted from any activity participation?	☐	☐

Signature of Parent/Guardian or Student/Patient if over 18

rev 3/17 amt

_____ Date: _____