

# Medical Questionnaire

 **You must bring this form to the screening.**

CONFIDENTIAL

Fill out the form completely. Heart conditions are affected by a number of variables. Answering honestly will help doctors accurately assess your cardiac health.

PARTICIPANT'S NAME (PRINT) \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

## To be completed by parent (if under 18)/participant (if over 18)

### Participant's Medical History

Allergic to latex?  Yes  No

Active in sports? What sport? \_\_\_\_\_  Yes  No

If NO, why? \_\_\_\_\_

High blood pressure?  Yes  No

If yes, when? \_\_\_\_\_

Pre-existing heart condition?  Yes  No

If yes, what? \_\_\_\_\_

Chronic illness?  Yes  No

If yes, what? \_\_\_\_\_

Previous injuries?  Yes  No

If yes, please list: \_\_\_\_\_

Previous hospitalization or visit to emergency room?  Yes  No

If yes, please list: \_\_\_\_\_

Surgeries?  Yes  No

If yes, please list: \_\_\_\_\_

Prescription medication?  Yes  No

If yes, please list: \_\_\_\_\_

### Family Medical History

Adopted?  Yes  No

Has anyone in your family developed heart disease under the age of 40?  Yes  No

Has anyone in your family died from heart disease under the age of 40?  Yes  No

Any unexplained or unexpected deaths in your family under the age of 40?  Yes  No

Has anyone in your family suffered from unexplained fainting or seizures?  Yes  No

Are there any known heart conditions for anyone in your family?  Yes  No

If yes, please explain who it was, and the heart condition \_\_\_\_\_

Completed by  participant  parent

### Participant's Social History

Have you ever used performance enhancing drugs, high-caffeine energy supplements or diet pills?

Yes  No

If Yes, how many per day \_\_\_\_\_ weekly \_\_\_\_\_

Do you drink energy drinks?

Yes  No

If Yes, how many per day \_\_\_\_\_

### Participant's Current Condition

Please check all that apply.

If you have had chest pain or pressure—When?

Resting  Walking  Exercise  None

If you have experienced skipped heartbeats—When?

Resting  Walking  Exercise  None

If you have experienced fainting or seizure—When?

Resting  Walking  Exercise  None

If you have experienced a fast heartbeat—When?

Resting  Walking  Exercise  None

If you have experienced unexplained fatigue—When?

Resting  Walking  Exercise  None

If you have experienced shortness of breath—When?

Resting  Walking  Exercise  None

If you have felt light-headed or dizzy—When?

Resting  Walking  Exercise  None

FOR OFFICE USE

REVIEWED BY: \_\_\_\_\_

