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: