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

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REVIEWED BY:

ERIC PAREDES SAVE A LIFE FOUNDATION