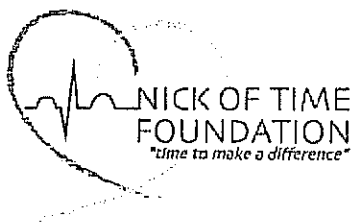


Record Number: _____



HEART HEALTH SURVEY

CONTACT INFORMATION

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Parent/ Guardian Email Address: _____

Please complete the following questions regarding the individual being screened:

DEMOGRAPHICS

Date of birth: _____ Age: _____

Gender: Male Female

Race/ethnicity: (check all that apply)

African-American/Black

Caucasian/White

Hispanic/Latino

Asian/Pacific Islander

Native American

Other: please specify: _____

Record Number: _____

SPORTS & PHYSICAL ACTIVITY

1.) Do you play on an organized sports team or compete in an individual sport? Yes No

If yes, what level: Club/Select Recreational/Intramural
 High School College Professional

If yes, what sport(s) do you play? (check all that apply)

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Baseball | <input type="checkbox"/> Golf | <input type="checkbox"/> Skiing |
| <input type="checkbox"/> Basketball | <input type="checkbox"/> Gymnastics | <input type="checkbox"/> Squash |
| <input type="checkbox"/> Cheer | <input type="checkbox"/> Hockey | <input type="checkbox"/> Swimming/Diving |
| <input type="checkbox"/> Cross country | <input type="checkbox"/> Lacrosse | <input type="checkbox"/> Tennis |
| <input type="checkbox"/> Cycling | <input type="checkbox"/> Martial arts | <input type="checkbox"/> Track |
| <input type="checkbox"/> Football | <input type="checkbox"/> Rowing | <input type="checkbox"/> Volleyball |
| <input type="checkbox"/> Field hockey | <input type="checkbox"/> Rugby | <input type="checkbox"/> Wrestling |
| <input type="checkbox"/> Fencing | <input type="checkbox"/> Soccer | <input type="checkbox"/> Softball |
| <input type="checkbox"/> Frisbee | <input type="checkbox"/> Softball | <input type="checkbox"/> Other: _____ |

2) Exercise and physical activity per week. On average I get... (check one)

- More than 10 hours of exercise or physical activity per week
 5-10 hours of exercise or physical activity per week
 2-5 hours of exercise or physical activity per week
 Less than 2 hours of exercise or physical activity per week
-

PAST MEDICAL HISTORY

Do you have any ongoing medical illnesses? Yes No

If yes, what illness? Asthma ADHD Diabetes High blood pressure

Other: _____

Are you taking any medication? Yes No

If yes, what medication? _____

Record Number: _____

HEART HEALTH QUESTIONS	Yes	No
1. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
2. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
3. Does your heart ever race or skip beats (irregular beats) during exercise?		
4. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> Other: _____		
5. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
6. Do you get lightheaded or feel more short of breath than expected during exercise?		
7. Have you ever had an unexplained seizure?		
8. Do you get more tired or short of breath more quickly than your friends during exercise?		
9. Has any family member or relative died of heart problems or had any unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
10. Does anyone in your family have: hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? (If yes, please circle.)		
11. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
12. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		