St. Francis Hospital
Roslyn, NY

CARDIAC SCREENING QUESTIONAIRE

PATIENT IDENTIFICATION

PLEASE COMPLETE THE FOLLOWING INFORMATION THAT APPEARS BELOW. DO NOT COMPLETE THE SECTION MARKED FOR PHYSICIAN USE ONLY.

Student's Name ______________________________

Address ______________________________

Home Phone ______________________________ Cell Phone ______________________________

Date of Birth ______________ Age_____ Grade_____ Gender: M or F School__________________ Sport ______________

Name/Address of Primary care Physician/Pediatrician ______________________________

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Phone Number of Primary care Physician/Pediatrician ______________________________

Parent/Guardian's Name ______________________________

Parent/Guardian's Address (if different from above) ______________________________

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Answer the following questions to the best of your ability. Please note if you are a parent or other legal guardian completing this form, the "You" refers to your child.

1. Have you ever had chest pain or discomfort? ❑ Yes ❑ No If yes, please describe ______________________________

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2. Have you ever passed out or almost passed out? ❑ Yes ❑ No If yes, please describe ______________________________

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3. Have you ever been short of breath or very fatigued with exercise? ❑ Yes ❑ No If yes, please describe ______________________________

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4. Have you ever been told that you have a heart murmur? ❑ Yes ❑ No If yes, please describe ______________________________

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5. Have you ever had high blood pressure? ❑ Yes ❑ No If yes, please describe ______________________________

6. Has anyone in your family died before age 50? Due to heart disease? ❑ Yes ❑ No If yes, please describe ______________________________

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7. Do you know of any close relatives less than 50 years old that are disabled with heart disease? ❑ Yes ❑ No
If yes, please describe ______________________________

8. Do you know of any family members with the following heart diseases: Cardiomyopathy, Long-qt Syndrome, Marfan Syndrome, Arrhythmias? ❑ Yes ❑ No If yes, please describe ______________________________

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9. Are you currently on any medication? ❑ Yes ❑ No If yes, please describe ______________________________

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Name:______________________________ Relationship to Patient: ______________________________

Signature: ______________________________ Date/Time:______________________________

Reviewed by: ______________________________

FOR PHYSICIAN USE ONLY:

1. Appropriate consent obtained and on hand? ❑ Yes ❑ No
2. Heart Murmur ❑ Yes ❑ No
3. Femoral pulses – Aortic Coarctation ❑ Yes ❑ No
4. Marfan Syndrome Physical Stigmata ❑ Yes ❑ No

Blood Pressure__________________ Pulse__________________ EKG__________________ Echo______________________

Physician Signature:______________________________ Date/Time ______________________________