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Patient Heart Questionnaire

1. Have you ever fainted?

During Exercise	Yes / No
Following Exercise	Yes / No
Unrelated to Exercise	Yes / No

2. Do you experience dizzy turns?

During Exercise	Yes / No
Following Exercise	Yes / No
Unrelated to Exercise	Yes / No

3. Do you experience palpitations? Yes / No
   (i.e. heavy, rapid or irregular heartbeat)

4. Do you experience chest pain, heaviness or tightness?

During Exercise	Yes / No
Following Exercise	Yes / No
Unrelated to Exercise	Yes / No

5. When exercising, do you feel you get unusually tired or breathless; more than you peers? Yes/No

   If YES, which? _____

6. Is there a history of heart disease in your family? Yes / No

   If YES, what? _____

7. Are you aware of any history of sudden cardiac death in your family? Yes / No

   If YES, who and what age? _____

Patient Name: _____ DOB: ____/____ /____

Signature of Patient OR Legal Guardian: _____

Today's Date: ____/____/____