Cardiovascular screening questionnaire to be used by the examining doctor

Applicable to all (starting) competitive athletes

Nr.	**MEDICAL HISTORY**	Y	N
1	Have you ever felt pressure on your chest or have you ever had chest pain after performing physical activities?		
2	Have you ever had any problems breathing or problems with coughing during or after physical activities?		
3	Have you ever been treated or admitted for asthma?		
4	Have you ever noticed that you were extremely tired after exercising at a normal intensity?		
5	Have you ever noticed that your heart was racing or that it skipped a beat?		
6	Have you been or are you being treated for cardiac arrhythmia?		
7	Have you ever felt dizzy or have you ever fainted during physical activities?		
8	Have you ever lost consciousness during or immediately after physical activities?		
9	Have you ever had an epileptic attack (seizure)?		
10	Do you have a heart murmur?		
11	Has anyone ever told you in the past that you should quit exercising due to a heart disease?		
12	Have you been diagnosed with any other heart disease, c.q. problem?		
13	Have you ever been feverish, had the flu or a serious viral infection for a longer period of time? (myocarditis, Pfeiffer)		
14	Have you ever suffered from rheumatic fever?		
15	Do you smoke or have you smoked in the past?		
16	Have you been or are you being treated for high blood pressure?		
17	Have you been or are you being treated for high cholesterol?		
18	Have you been or are you being treated for diabetes?		
19	Do you have any allergies?		
20	Do you use or have you used any medications in the past?		

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Nr.	YOUR FAMILY'S MEDICAL HISTORY * family is understood to mean close family members, but also (second) cousins	Y	N	0-50 y	50-75 y	75 y or older
A.	Has anyone in your family *					
	1. died suddenly and unexpectedly?					
	2. unexplainably drowned while swimming?					
	3. unexplainably caused a traffic accident?					
	4. been diagnosed with high blood pressure?					
	5. been treated for heart complaints?					
	6. had a heart infarct or chest pain?					
	7. had percutaneous angioplasty?					
	8. undergone a heart (heart valves or bypass) of surgery?					
	9. been treated for regular fainting or dizziness?					
	10. been treated for an irregular heartbeat?					
	11. got a pacemaker or defibrillator?					
	12. had unexplained convulsions?					
	13. got a heart muscle disease?					
	14. undergone surgery for a congenital heart defect?					
	15. undergone or will they undergo a heart transplant?					
B.	Did anyone in your family die of cot death?					
C.	Does anyone in your family have the Marfan syndrome?					

Name: Date:

Signature: Date of birth: