**ID:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_  
**Please fill out the following patient information:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Demographics**  Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Age: \_\_\_\_\_\_\_\_\_  Gender: ⬜ Male ⬜ Female ⬜ Other | **Race (check all that apply):**   * Hawaiian * Other Pacific Islander * Asian | | * Black or African American * Native American/Native Alaskan * White * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
|  | | | | |
| **What sport(s) do you participate in (check all that apply)** | | | | |
| * Baseball * Basketball * Cheer * Cross Country * Football * Golf * Gymnastics | | * Hockey * Jiu Jitsu * Other Martial Arts * Lacrosse * Rowing/Paddling * Rugby * Soccer | | * Softball * Surfing * Swimming/Diving * Tennis * Track * Volleyball * Wrestling |
| * Others: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |

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| --- | --- | --- | --- | --- | --- | --- |
| **Past Medical History** | | | | | | |
| Do you have any medical problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Do you take any medications? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you had a physical in the past 12 months? ⬜ Yes ⬜ No | | | | |
|  | | | | | | |
| **Personal Heart History** | **Patient** | | **Physician Use Only** | | |
| Have you ever had any of the following? | **No** | **Yes** | **No** | **Yes** | |
| * Chest pain or discomfort **during** exercise? |  |  |  |  | |
| * Passing out **during** exercise? |  |  |  |  | |
| * Shortness of breath requiring you to stop exercising? |  |  |  |  | |
| **Family History** | **No** | **Yes** | **No** | **Yes** | |
| Has a close family member died unexpectedly from a heart condition or had cardiac arrest before the age of 50? |  |  |  |  | |
| Does a family member have any of the following? | **--------** | **--------** | **--------** | **--------** | |
| * Hypertrophic Cardiomyopathy (HCM) |  |  |  |  | |
| * Dilated Cardiomyopathy (DCM) |  |  |  |  | |
| * Long-QT Syndrome |  |  |  |  | |
| * Brugada Syndrome |  |  |  |  | |
| * Arrhythmogenic Right Ventricular Dysplasia |  |  |  |  | |
| * Marfan Syndrome |  |  |  |  | |
| * Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |  | |

**This side for physician use only**

**Physical Examination**

* Heart murmur (Supine / Standing / Valsalva) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Femoral Pulses (Normal / Abnormal) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
    
  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Physical Stigmata of Marfans (Yes / No) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
    
  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Blood Pressure - Right: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Left: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
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| **ECG:** |

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| **Further work-up:** |