

Cardiac Screening Medical Questionnaire

This is a medical questionnaire for all individuals who would like to participate in the cardiac health screening event hosted by Cardiac Health Diagnostics Limited, on behalf of Welsh Hearts (Calonnau Cymru). This medical questionnaire must be completed before your screening appointment and brought with you on the day. Individuals CANNOT be screened without handing in their medical questionnaire. Information on this questionnaire is confidential and only accessed by the relevant staff and medical professionals.

Personal Details

Full Name		Date of Screening		
If you are under 16, please also include parent/guardian name				
Parent/Guardian Full Name				
Home Address incl. Post code				
Date of Birth		Gender		
Contact Telephone Number				
Email address				
Ethnicity. Please tick one.				
British	Irish	Turkish/Cypriot	Greek/Cypriot	White and black Caribbean
White and Asian	Caribbean	White and black African	East African	West African
North African	Indian	Pakistani	Bangladeshi	Vietnamese
Other (please specify)				
Height		cm	Weight	kg
Do you consider yourself to have any of the following disabilities or learning difficulties? Please mark as Y (Yes) or N (No)				
Visual impairment	Other physical disability	Temporary disability after illness		
Hearing impairment	Disability affecting mobility/wheelchair user	Profound / complex disabilities		
Other (please specify)				

Do you require any special assistance on the day of your screening appointment? YES / NO
If YES, please specify below.

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Doctor Details

Doctors Name	
Doctor Address incl. Post code	
Contact Telephone Number	

Please answer the following questions honestly, providing as much information as possible.

1. Do you often experience ‘dizzy spells’?

Dizzy spells can be described as feeling faint, woozy, weak or unsteady. Please mark as Y (Yes) or N (No)

During Exercise		If Y. How often?		When was your most recent?	
Following Exercise		If Y. How often?		When was your most recent?	
Unrelated to Exercise		If Y. How often?		When was your most recent?	

Please describe your experience when having a ‘dizzy spell’ if you said YES to any of the above questions. If you said NO to the above questions, please move on to question 2.

During Exercise	
Following Exercise	
Unrelated to Exercise	

2. Have you ever fainted?

Please mark as Y (Yes) or N (No)

During Exercise		If Y. How often?		When was your most recent?	
Following Exercise		If Y. How often?		When was your most recent?	
Unrelated to Exercise		If Y. How often?		When was your most recent?	

Please describe your experience when fainting if you said YES to any of the above questions. If you said NO to the above questions, please move on to question 3.

During Exercise	
Following Exercise	
Unrelated to Exercise	

3. Do you experience palpitations?

Palpitations can be described as the feeling of the heart racing, pounding and the heartbeat feels irregular or rapid.

Please mark as Y (Yes) or N (No)

During Exercise		If Y. How often?		When was your most recent?	
Following Exercise		If Y. How often?		When was your most recent?	
Unrelated to Exercise		If Y. How often?		When was your most recent?	

Please describe your experience when having palpitations if you said YES to any of the above questions. If you said NO to the above questions, please move on to question 4.

During Exercise	
Following Exercise	
Unrelated to Exercise	

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

Please mark as Y (Yes) or N (No)

During Exercise		If Y. How often?		When was your most recent?	
Following Exercise		If Y. How often?		When was your most recent?	
Unrelated to Exercise		If Y. How often?		When was your most recent?	

Please describe your experience when feeling chest pain, heaviness or tightness if you said YES to any of the above questions. If you said NO to the above questions, please move on to question 5.

During Exercise	
Following Exercise	
Unrelated to Exercise	

5. Do you exercise regularly? YES / NO (please circle correct response)

If YES, how many hours per week do you exercise? _____

If YES, how many days per week do you exercise? _____

Please describe the types of exercise you participate in below:

6. Do you play sport as part of a team? YES / NO (please circle correct response)

Please explain what sport you play as part of a team below:

7. Are you a competitive athlete? YES / NO (please circle correct response)

A competitive athlete can be described as a person who is trained in physical exercise or sport to participate in competitions.

If YES, in which sport? _____

8. Do you aspire to become a competitive athlete? YES / NO (please circle correct response)

If YES, in which sport? _____

9. Do you ever feel more out of breath or easily tired than other people/members of your team when you exercise? YES / NO (please circle correct response)

If YES, please describe your experience below:

10. How many years have you been regularly exercising/participating in sport? _____

Do you have a family history of any of the following? Please mark as Y (Yes) or N (No)

High Blood Pressure		High Cholesterol		Diabetes	
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11. Is there anyone in your family who has heart disease under the age of 50? YES / NO (please circle correct response)

If you have ticked any of the above boxes, can you please describe a) the relation to you b) age of onset

High Blood Pressure	
High Cholesterol	
Diabetes	

12. Has anyone in your family suddenly died under the age of 50? YES / NO (please circle correct response)

If YES, could you please describe a) the circumstances in which this occurred b) age the death occurred and c) how the individual(s) were related to you.

Thank you for taking the time to complete this questionnaire. Please bring this with you to your cardiac screening appointment.