CARDIAC SCREENING QUESTIONNAIRE

NAME _____ ID# _____ AGE ____ SEX ____ DATE _____

		Y	N
1.	Have you ever had any of the following?		
	a. Episodes of passing out	☐	☐
	b. Unusual shortness of breath	☐	☐
	c. Unexplained fatigue	☐	☐
	d. Frequent dizziness or lightheadedness	☐	☐
2.	Do you ever experience chest tightness, heaviness, pressure, or pain?	☐	☐
3.	Are you currently taking any of the following medications? (please circle)		
	a. Anti-anginals? (Nitroglycerin, Nitro-Bid, Isordil, Isosorbide Dinitrate, Nitro-patch)	☐	☐
	b. Calcium Channel Blockers? (Cardizem, Diltiazem, Isoptin, Calan, Verapamil, Nifedipine, Procardia, Adalat)	☐	☐
	c. Beta Blockers? (Corgard, Lopressor, Tenormin, Metaprolol, Propanolol, Inderal, Visken, Timolol, Atenolol)	☐	☐
	d. Anti-arrhythmics? (Quindine, Quinaglute, Norpace, Pronestyl, Procan-SR, Procainamide, Tambacor, Amiodarone, Mexitil, Tocainide, Encainide, Tonocard, Enkaid)	☐	☐
	e. Digitalis? (Lanoxin, Digoxin)	☐	☐
	f. Diuretics (water pills)? (Lasix, Oretic, Esidrex, Spironolactone, Aldactone)	☐	☐
	g. Anti-hypertensives (blood pressure pills)? (Aldomet, Captopril, Capoten, Apresoline, Minipress, Maxide, Dyazide, Vasotec, Minoxidil, Indapamide, Lozol, Methyl Dopa, Catapres)	☐	☐
4.	Have you ever had palpitations, skipped beats, an irregular beat, or slow heart beat?	☐	☐

		Y	N
5.	Do you have a family history of cardiac sudden death? (brothers, sisters, parents, grandparents, children)	☐	☐
6.	Are you a heart patient currently under the care of a doctor?	☐	☐
7.	Do you have a history of rheumatic fever?	☐	☐
8.	Do you have mitral valve prolapse?	☐	☐
9.	Do you have a history of a heart murmur?	☐	☐
10.	Are you over 70?	☐	☐
11.	Do you have high blood pressure?	☐	☐
12.	Do you have a pacemaker? Type: _____ Rate: _____	☐	☐
13.	Have you ever had a MI (heart attack)? If so, when _____	☐	☐
14.	Do you have chronic lung disease, bronchitis, emphysema, wheezing, or asthma?	☐	☐
15.	Have you ever had heart surgery?	☐	☐
16.	Have you ever had an abnormal exercise test? (eg. treadmill)	☐	☐
17.	Have you ever had an abnormal EKG?	☐	☐
18.	Do you have a history of any of the following?		
	a. High cholesterol?	☐	☐
	b. Smoking more than one pack of cigarettes per day?	☐	☐
	c. Diabetes?	☐	☐
	d. High blood pressure?	☐	☐
	e. Family history of heart attacks?	☐	☐
	f. Being more than 30 lbs. overweight?	☐	☐

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