Rev. 01–20

ADOLESCENT QUESTIONNAIRE

Name: ______________________ D.O.B.: ______________________

Date: ______________________ Age: ______________________

Form filled out by: ______________________

PERSONAL HISTORY

1. Do you ever experience chest pain when exercising? YES NO
2. Have you ever fainted due to an unknown cause? YES NO
3. Do you experience shortness of breath or fatigue with exercise? YES NO
4. a) Do you have a history of asthma? YES NO
   b) If yes, what medications are you on? ______________________
5. Do you ever feel your heart beat faster than usual? YES NO
6. Do you ever feel your heart skip a beat? YES NO
7. Have you ever had a heart murmur? YES NO
8. Have you ever had high blood pressure? YES NO
9. Do you have a history of a sports injury? YES NO
10. If you answered yes to any of the above, please explain:

FAMILY HISTORY

11. Has anyone in your family died before 50 years of age due to heart disease? YES NO
12. Has anyone in your family been disabled before 50 years of age due to heart disease? YES NO
13. Has anyone in your family ever had a history of sudden cardiac death, heart arrhythmias or cardiomyopathy? YES NO
14. If you answered yes to any of the above, please explain:

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