Sudden Cardiac Death Prevention Screening

Name:_____ M:____ F:____ Age:_____ Date of Birth: ___/___/_____

Ethnicity: __American Indian __Asian __Black/African American __Latino/Hispanic __White/Caucasian

Grade: _____ School: _____ Ht:_____Wt:_____Activities: _____

Mailing Address/City/State/Zip: _____

Parent/Guardian Name(if patient is a minor): _____ Relationship: _____

Parent Phone: _____ Screening Location: _____ Doctor: _____

Give brief explanation for any YES answers. Parents, please complete with your child present.

HEALTH HISTORY	YES	NO
1. Have you ever passed out or fainted during or after exercise?	☐	☐
2. Have you ever been dizzy during or after exercise?	☐	☐
3. Have you ever had chest pain during or after exercise?	☐	☐
4. Do you seem to tire more easily than others doing the same activity?	☐	☐
5. Have you ever felt your heart racing or felt it skipped a beat?	☐	☐
6. Have you had high blood pressure or high cholesterol?	☐	☐
7. Have you ever been told you have a heart murmur?	☐	☐
8. Any family history of cardiac death before age 50?	☐	☐
9. Have you had a severe viral infection within the past month?	☐	☐
10. Have you ever been diagnosed with heart problems?	☐	☐
11. Do you have a family history of heart disease?	☐	☐
12. Do you cough, wheeze or have trouble breathing during or after activity?	☐	☐
13. Do you have asthma? If YES, do you use an inhaler? Type _____	☐	☐
14. Do you have seasonal allergies that require medical treatment?	☐	☐
15. Have you had a medical illness or injury since your last sports physical?	☐	☐
16. Are you taking any prescription or over the counter medications?	☐	☐
17. Do you have any other allergies, i.e. pollen, food, medicine or bees?	☐	☐
18. Do you use tobacco products?	☐	☐
19. Do you consume alcoholic beverages?	☐	☐
20. Do you consume caffeine daily?	☐	☐
21. Do you have an eating disorder i.e. anorexia or bulimia?	☐	☐
22. Do you have persistent headaches, visual changes or frequent dizziness?	☐	☐
23. Do you use muscle enhancing substances?	☐	☐
24. Have you been diagnosed with Marfan's Syndrome?	☐	☐
25. Have you ever previously been restricted from any activity participation?	☐	☐
26. Do you drink energy drinks? If yes, how many per day? _____	☐	☐

Signature of Parent/Guardian or Student/Patient if over 18

rev 03/19 at

_____ Date: _____

Marfan Syndrome Characteristics

Marfan syndrome is an inherited (genetic) disorder that affects the body's connective tissue. The disorder can affect the heart, blood vessels, bones, eyes and/or lungs.

Check the box of any of these features you are aware that you have:

- ☐ Tall and slender
- ☐ Arms, legs, fingers and toes that seem disproportionately long
- ☐ Flat feet
- ☐ Highly arched palate and crowded teeth
- ☐ Joints that are too flexible
- ☐ Learning disability
- ☐ Nearsightedness
- ☐ Small lower jaw (micrognathia)
- ☐ Spine that curves to one side (scoliosis)
- ☐ Thin, narrow face
- ☐ Chest that sinks in - funnel chest, or sticks out - pigeon chest
- ☐ Heart palpitations
- ☐ Hernias
- ☐ Hunched back (kyphosis)
- ☐ Stretch marks, not from pregnancy or obesity
- ☐ Deviated septum
- ☐ GERD – gastro esophageal reflux disease
- ☐ Degenerative disk disease
- ☐ Leaky heart valve
- ☐ Mitral valve prolapse
- ☐ Long thin fingers

This information is provided to the best of my knowledge

Patient Name: _____DOB:_____ Date: _____

Agreement, Consent & Release of Liability

The undersigned persons hereby agree to the administration by Transmed, Inc. (dba Screening America) of a heart screening (including a blood pressure reading, an electrocardiogram, and an echocardiogram) on the Patient for the limited purpose of obtaining data that can be used to detect indications of possible Hypertrophic Cardiomyopathy, which has been shown to be a leading cause of sudden cardiac death in young people. The undersigned persons understand the screening and resulting data do not always result in the discovery of existing abnormalities, are provided for informational purposes only, do not in any way constitute a medical diagnosis, and that additional procedures not provided by Transmed, Inc. will be required in the event a medical diagnosis is desired. The undersigned persons acknowledge and agree it is their sole responsibility to consult with Patient's personal physician with regard to the results of this screening and to obtain any follow-up care determined by that physician to be appropriate. Further, the undersigned persons understand that this screening is not a complete physical exam, and is not a substitute therefor.

The undersigned persons agree that they have truthfully disclosed all of Patient's health related history and information, and all their questions about the screening have been answered. The undersigned persons understand that Transmed, Inc. will provide Patient's medical health information and the data obtained from this screening to an independent, third-party physician for review, and they consent thereto. The undersigned persons further acknowledge and agree that said physician's review and decision as to the normalcy or abnormality of Patient's screening results is not the act of Transmed, Inc., is being provided independently of Transmed, Inc., and Transmed, Inc. is not responsible or liable for such physician's review or decision as to normalcy or abnormality.

The undersigned persons, on behalf of the Patient, themselves and their legal representatives, heirs, successors and assigns, do hereby release and forever discharge Transmed, Inc. (dba Screening America), and its agents, employees, successors and assigns, from any and all claims, losses, costs, expenses, and damages of any kind involving or related to errors, omissions, or negligence in the performance of the screening procedures or involving errors, omissions, negligence or intentional misconduct by the third-party physician in reviewing the screening data or determining the normalcy or abnormality of such data. Without limiting the foregoing, the undersigned persons agree that if any condition exists that is not detected by the screening, Transmed, Inc. (dba Screening America), and its agents, employees, successors and assigns, shall not be held liable.

I HAVE READ THIS AGREEMENT, CONSENT AND RELEASE OF LIABILITY, UNDERSTAND ITS TERMS, UNDERSTAND THAT I AM GIVING UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND HAVE SIGNED IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT, ASSURANCE OR GUARANTEE MADE TO ME. FURTHER, I INTEND MY SIGNATURE TO BE A COMPLETE AND UNCONDITIONAL WAIVER AND RELEASE OF ALL LIABILITY OF TRANSMED, INC. (dba SCREENING AMERICA), AND ITS AGENTS, EMPLOYEES, SUCCESSORS AND ASSIGNS TO THE GREATEST EXTENT ALLOWED BY LAW.

Patient's Name: _____ Signature: _____ (if over 18)

Signature of Parent or Legal Guardian: _____ (if Patient is a minor)

Printed Name of Parent or Legal Guardian: _____ Date: _____

Please check one: ☐ Mother ☐ Father ☐ Non-parent legal guardian

edited 7/15dhk