Questionnaire for Stimulant Medication

Patient Name:_____

Date of Birth:_____

Date of Service:_____

Patient and Family History of any of the following: Circle yes or no

1.	History of fainting or dizziness (particularly with exercise)	yes	no
2.	Seizures	yes	no
3.	Rheumatic Fever	yes	no
4.	Chest Pain or Shortness of Breath with exercise	yes	no
5.	Unexplained, noticeable change in exercise tolerance	yes	no
6.	Palpitations, increased heart rate, extra or skipped heartbeats	yes	no
7.	History of high blood pressure	yes	no
8.	History of heart murmur other than innocent or functional Murmur or history of other heart problems	yes	no
9.	Intercurrent viral illness with chest pains or palpitations	yes	no
10.	Current Medications (prescribed and over the counter)	_____	
11.	Health Supplements (nonprescribed)	_____	

Family History of any of the following: Circle yes or no

1.	Sudden or unexplained death in someone young	yes	No
2.	SCD or "heart attack" in member <35 years of age	yes	no
3.	Sudden death during exercise	yes	no
4.	Cardiac Arrhythmias	yes	no
5.	HCM or other Cardiomyopathy, including dilated cardiomyopathy And right ventricular cardiomyopathy (right ventricular dysplasia)	yes	no
6.	LQTS, short-QT syndrome, or Bruguda syndrome	yes	no
7.	WPW or similar abnormal rhythm conditions	yes	no
8.	Event requiring resuscitation in young members (< 35 years of age), Including syncope, requiring resuscitation.	yes	no
9.	Marfan syndrome	yes	no