**Appendix 1 (Health Questionnaire and Consent Form)**

**Screening for Sudden Cardiac Death Project Questionnaire**

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| **For Office Use Only** |
| Date of On-Site Screening\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Consent SignedYesNo | Student Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Seen by Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Results DiscussionNot requiredRequired | Follow Up RequiredYesNo |

**Demographic variables (please circle/tick appropriate answer)**

|  |  |
| --- | --- |
| *Age*   | *Gender*  Male Female  |
| *Smoking Status*Non-SmokerSmokerEx-Smoker\*Ex-Smoker (Has refrained from smoking >3 months ago) | Are you on any *regular medications*?Yes NoIf Yes, please write the names: |
| *Ethnicity*White Maltese ❑ Southern European ❑ Northern European ❑Black East African ❑ West African ❑ North African ❑ Caribbean ❑ Asian ❑Mixed ❑Other ❑ | Have you ever had previous contact with Cardiology Services?Yes NoIf yes, are you currently being investigated for a cardiac condition?Yes NoIf yes, please specify |

1. **Have you ever fainted? (please circle/tick appropriate answer)**

|  |  |  |
| --- | --- | --- |
| During Exercise | Yes / No | If yes, please describe the circumstances |
| Following Exercise | Yes / No |
| Unrelated to Exercise | Yes / No |

1. **If you have answered at least 1 yes in question 1, please answer the following. Otherwise move on to question 3. (please circle appropriate answer)**

|  |  |
| --- | --- |
| Was this associated with blurred vision? | Yes / No |
| Did you feel lightheaded/nauseous/weak before? | Yes / No |
| Were you in a hot or warm environment? | Yes / No |
| Have you experienced this more than twice? | Yes / No |
| Did you feel that your heart was abnormal?i.e. racing or skipping beats?  | Yes / No |
| Did you completely pass out during the faint? | Yes / No |
| If you passed out, were you tired after? | Yes / No |
| If you passed out and someone witnessed it, did they notice you were pale in colour | Yes / No / Not-Witnessed |
| How long did the faint last? | Seconds / 1-3 minutes / >3 minutes |

1. **Do you experience dizzy turns? (please circle appropriate answer)**

|  |  |  |
| --- | --- | --- |
| During Exercise | Yes / No | If yes, please describe the circumstances |
| Following Exercise | Yes / No |
| Unrelated to Exercise | Yes / No |

1. **Do you experience chest pains, heaviness, pressure or chest tightness? (please circle appropriate answer)**

|  |  |  |
| --- | --- | --- |
| During Exercise | Yes / No | If yes, please describe the circumstances |
| Following Exercise | Yes / No |
| Unrelated to Exercise | Yes / No |

1. **If you have answered at least 1 yes in question 4, please answer the following. Otherwise move on to question 6. (please circle appropriate answer)**

|  |  |
| --- | --- |
| Does the pain occur during exercise or emotional stress? | Yes / No |
| Does the pain feel dull, achy, heavy and located in the middle of the chest, and/or radiate to the jaw, neck, shoulders or arms? | Yes / No |
| Is the pain relieved within 5 minutes of rest? | Yes / No |
| Is the pain worse with deep inspiration? | Yes / No |
| Is the pain worsened with arm movement? | Yes / No |
| Do you have asthma? | Yes / No |
| If you passed out and someone witnessed it, did they notice you were pale in colour | Yes / No / Not-Witnessed |

1. **Palpitations or heart fluttering (a fluttering feeling felt in the chest at rest) (please circle appropriate answer)**

|  |  |
| --- | --- |
| Have you ever experienced palpitations  | Yes / No |
| How often? | Daily Weekly Monthly 6 months 6-12 months > 12 months |
| Episode of palpitations followed by loss of consciousness? | Yes / No |

1. **Breathlessness (please circle appropriate answer)**

|  |  |
| --- | --- |
| Do you feel that you are more breathless or more easily tired than your team mates? | Yes / No |
| Do you feel a burning sensation in your throat? | Daily Weekly Monthly 6 months 6-12 months > 12 months |
| Do you have difficulty swallowing or were constantly clearing your throat? | Yes / No |
| Do you feel nauseous at the same time? | Yes / No |
| Do you have a lung disease (including Asthma)? | Yes / No |

1. **Family History (Parents, Brothers/Sisters, Siblings, Great Grandparents) of Cardiovascular risk factors (please circle appropriate answer)**

|  |  |  |  |
| --- | --- | --- | --- |
| High Blood PressureYes / No | High CholesterolYes / No | DiabetesYes / No | ObesityYes / No |

1. **Family history (please circle appropriate answer)**

|  |  |
| --- | --- |
| Is there a family history of heart disease under the age of 50? | Yes / No |
| If yes, what is the condition? |  |
|  |  |
| Did anyone die of heart disease under the age of 50? | Yes / No |
| If yes, what was the reason for his/her death? (Including drowning or sudden infant death syndrome) |  |
| If yes, what was the circumstance of his/her death? | During SleepAt restDuring ExerciseDuring competitive sports |
| If yes, how are they related to you?. |  |
| If yes, what is the age at the time of death. | Yes / No |
|  |  |
| Does anyone in your family have one of the following conditions? | Arrhythmogenic Ventricular Cardiomyopathy ❑Hypertrophic Cardiomyopathy ❑Wolff Parkinson White Syndrome ❑Brugada Syndrome ❑Long/Short QT syndrome ❑Catecholaminergic polymorphic ventricular tachycardia ❑Idiopathic ventricular tachycardia/fibrillation ❑Marfan’s Syndrome ❑ |

1. **Sport/Exercise (please circle appropriate answer)**

|  |  |
| --- | --- |
| Approximately how many days per week are you physically active? | Days \_\_\_\_\_\_\_\_ |
| On average how many hours per week are you physically active? | < 2 hours 2-5 hours  5-10 hours > 10hours |
| What sport or exercise do you participate in? | FootballBasketballNetballHandballTennisFencingRugby | SwimmingAthleticsWaterpoloVolleyballWrestlingDancingGym  | BaseballCyclingSquashTriathlonKarateKick BoxingNot Applicable |
|  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| What level do you play/complete at?(Write sporting discipline on the line provided if you participate in more than one) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ RecreationalSchoolClub (Semi-Professional)Club (Professional)National | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ RecreationalSchoolClub (Semi-Professional)Club (Professional)National |
| How many years have you participated in sport/regular exercise? | Not Applicable < 1 year 1-2 years3-4 years >5 years |

**Consent Form for Cardiac Screening**

**It is extremely important that you have read and understood the information sheet provided with this consent form.**

**Please tick** the following box to confirm you have fully read and understood the screening information on the attached. ❑

**Test Procedure: An Electrocardiogram (or ECG for short) is a simple, non-invasive** and painless test that examines the electrical activity within your heart. Small stickers are placed on your chest. Flexible leads that extend from the ECG machine are then attached to these stickers. The electrical rhythm of your heart is recorded and printed. Where possible, a female technician will be performing ECG tracings on female individuals. If you wish, a friend or chaperone can accompany you during the procedure.

**Results:** All results are treated in the strictest of confidence. The study group may contact you in the future for information about any follow up tests you may require. One should take note that the results from such screenings will appear abnormal in a small percentage of cases and follow up tests will be required to further evaluate cardiac health. Within 4 working weeks, the study group will be sending a letter to notify you (your parents) with the outcomes of both the questionnaire and ECG.

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**Statement:** I have read and understood the implications of further testing, outlined in the information sheet. Questions concerning the testing procedure have been answered to my satisfaction. I also understand that I am free to withdraw consent and discontinue participating in any procedures without giving a reason. I have also been informed that the information derived from these tests is confidential and will not be disclosed to anyone other than my doctor or others who are involved within my care. However, I do agree that the information from these tests (including future evaluations) will be held (anonymously) on a database for research purposes. For more information or questions, please email on scdmaltascreeningprogram@gmail.com or call on 79847989.

If you would prefer not to be contacted to be offered repeat testing please tick the box. ❑

Participant Signature ………………………………………………………………………………....

Participant Full Name …….…………………………...……………………………………………..

Parent Signature …...………………………………………………………………………………....

Parent Full Name ………….…………………………...……………………………………………..

Contact Telephone Number …………………………………………………………………………

DATE……………………….........................................................................................................

\*Parental signature required if individual is aged under 16 years.