awareness, support, screening and research
01737 363222 cry@c-r-y.org.uk www.c-r-y.org.uk

CRY Mobile Screening Health Questionnaire

Please complete 3 pages for the health questionnaire and the consent form on page 4

For Office Use Only			
Payment Received:	Questionnaire Checked:	Info box ticked:	Consent Signed:
Seen By Doctor:	Follow-up Required: Yes	No	
Additional Notes:		Result:	
Height ……cm	**Weight ……Kg**	**Blood Pressure ……/…….mmHg**	
Patient ID No:			

Personal Details

Full Name:	NHS Number:	Date of Screening:
Parents names (*if under 17*):		
Home *(correspondence)* address: **POSTCODE:**	Doctor's name and Address: **POSTCODE:**	
Phone Number:	Doctor's Phone Number:	
E-mail:		
Date of Birth:	Age:	Gender: **MALE / FEMALE**
Have you ever smoked? **YES / NO** If yes, how long for? How many each day? If you have given up when was this and how long did you smoke for?	Are you taking any medication? **YES / NO** If yes please describe?	

Ethnicity *(please tick the appropriate box)*

White	**Mixed**	**Black**	**Asian**	**Other**
English ☐	White and Black Caribbean ☐	Caribbean ☐	Indian ☐	Arab ☐
Welsh ☐				
Scottish ☐	White and Black African ☐	East African ☐	Pakistani ☐	Polynesian ☐
Northern Irish ☐				
British ☐	White and Asian ☐	West African ☐	Bangladeshi ☐	Any other ethnic group ☐ please describe
Irish ☐	Any othe Mixed / Multiple ethnic background ☐ please describe	North African ☐	Chinese ☐	
Any other white background ☐ please describe		Any other Black background ☐ please describe	Any other Asian background ☐ please describe	

Symptoms

1.Have you ever fainted?

During Exercise	**Yes / No**	How recently did this occur?	If yes, please describe the circumstances
Following Exercise	**Yes / No**	How recently did this occur?	
Unrelated to exercise	**Yes / No**	How recently did this occur?	

2. Do you experience dizzy turns?

During Exercise	**Yes / No**	How recently did this occur?	If yes, please describe the circumstances
Following Exercise	**Yes / No**	How recently did this occur?	
Unrelated to exercise	**Yes / No**	How recently did this occur?	

3. Do you experience palpitations? *(palpitations are a fluttering in your chest that you can notice whilst resting)*

Yes / No	If yes, how recently and please describe the circumstances

4. Do you experience chest pain, heaviness or tightness?

During Exercise	**Yes / No**	If yes, please describe the circumstances
Following Exercise	**Yes / No**	
Unrelated to exercise	**Yes / No**	

5. Do you feel that you are more breathless or more easily tired than your team mates?

Yes / No	If yes, please describe the circumstances

Family History

6. Is there a family history of:

High Blood Pressure **YES / NO**	High Cholesterol **YES / NO**	Diabetes **YES / NO**
Which family member(s)?	Which family member(s)?	Which family member(s)?

7. Is there a family history of heart disease in anyone under the age of 50?

Yes / No	If yes, how are they related to you, what is the diagnosis? Please state the age of onset

8. Has anyone died suddenly in your family under the age of 50?

Yes / No	If yes, how were they related to you? Please describe the circumstances and at what age did the death occur

Cardiac Screening

9a. Have you had cardiac screening before (inc ECG?) **YES / NO**	If Yes, was this with CRY? **YES / NO**	If CRY what Year? **……** What was the result? *(please circle)*: **Normal / Repeat Recommended / Referral**
9b. Have you have been screened by another organisation/hospital? **YES / NO**	If Yes, when was this done? **……..**	What was the result? *(please circle)*: **Normal / Repeat Recommended / Referral**
9c. Have you ever been referred to see a Cardiologist for further tests?	**YES / NO**	If YES, when? **……**
9d. Have you ever received a diagnosis of a cardiac condition?	**YES / NO**	If YES, what was the diagnosis? **……**
9e. Any additional information we should be aware of?	……	

Sport/Exercise

10. Approximately, how many days per week are you physically active (playing sport/exercising)?	**……**
11. On average, how many hours per week are you physically active (playing sport/exercising)?	**……**
12. What sport/exercise do you play/participate in?	**……**
13. What level do you play/compete at? *(please circle any that are applicable)*	Recreational School Club County National International Professional
14. How long (for how many years) have you participated in sport/regular exercise?	**……**

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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.

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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 at strategic points 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 out on thermal paper. An Echocardiogram (ECHO) is an ultrasound scan of the heart that measures cardiac dimensions and the flow of the blood in and out of the heart. Just like a sonogram of a pregnant woman, the scan is painless, non-invasive and takes no more than 20 min. Where possible, female physiologist will be used to perform cardiac evaluation on female individuals. If you wish, a friend or chaperone can accompany you during the procedures. All medical personnel who are linked to CRY are verified and approved by Professor Sanjay Sharma. Please also note that there may be doctors or other health care professionals in training present at some screenings. All results are treated in the strictest of confidence. CRY may contact you in the future for information about any follow up tests you may require.

Results: It should be noted that the results will appear abnormal in a small percentage of cases and follow up tests will be required to further evaluate cardiac health. CRY aims to notify you (or your parents if you are under 17) and your GP within 4 working weeks after the screening event.

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STATEMENT**: I have read and understood the implications of further testing, outlined in the CRY Information Sheet. I understand that in the rare event an abnormality is confirmed, this may affect some types of mortgage and health/life insurance applications and that it may also affect some careers. 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 will be held on a database at CRY and can be used anonymously for research purposes. For more information on research go to www.c-r-y.org.uk**

CRY may contact you in the future to have your tests repeated for research purposes. If you wish to be contacted to be offered repeat testing please tick the box. ☐

(SIGNATURE)…….....

NAME OF CLIENT
(PRINTED)……..……..

CONTACT TEL. NO. ……..……..……..

PARENTS
SIGNATURE…….....DATE…….....
(Required if individual is under 17 years of age)