



[www.codystephensfoundation.org](http://www.codystephensfoundation.org)

**Please circle Yes or No as the questions relate to you.**

**Be sure to ask the screening staff or volunteers if you have any questions or concerns about answering them.**

Name: \_\_\_\_\_

- |   |     |    |
|---|-----|----|
| ➤ Have you ever experienced chest pain or discomfort with exercise?                               | YES | NO |
| ➤ Have you ever passed out or nearly passed out?  | YES | NO |
| ➤ Have you ever had excessive shortness of breath or fatigue with exercise?                       | YES | NO |
| ➤ Have you been told you have a heart murmur?   | YES | NO |
| ➤ Have you had high blood pressure?   | YES | NO |
| ➤ Does anyone in your family have genetic or heart arrhythmia problems?                           | YES | NO |
| ➤ Has anyone in your family under the age of 50 died suddenly or unexpectedly from heart disease? | YES | NO |
| ➤ Has anyone in your family under the age of 50 been disabled from heart disease?                 | YES | NO |
| ➤ Have you had a prior restriction from participation in sports for heart issues?                 | YES | NO |
| ➤ Have you had a physician order a heart test for you?  | YES | NO |