FOOTBALL ASSOCIATION OF IRELAND

CARDIAC SCREENING QUESTIONNAIRE

NAME:

DATE OF BIRTH:

ADDRESS:

PARENT/GUARDIAN:

CONTACT NUMBER:

- Have you any previous history of heart disease?
- Yes ☐ No ☐

- Is there any family history of sudden cardiac death in close relatives (brothers, sisters, parents), under 50 years of age ?
- Yes ☐ No ☐

- Do you suffer from or have you suffered with chest pains when exercising?
- Yes ☐ No ☐

- Do you suffer from or have you suffered with breathlessness when exercising?
- Yes ☐ No ☐

- Do you suffer from or have you suffered with dizziness when exercising?
- Yes ☐ No ☐

- Do you suffer from or have you suffered with
- palpitations (a very fast or skipped heart beat) when exercising?
- Yes ☐ No ☐

PLEASE NOTE:
1. If you are between 14-16 years old you should complete this questionnaire with the assistance of your parent(s)/ guardian
2. If you reply “yes” to any of the questions above you should make an appointment to see your Family Doctor. Please bring the completed questionnaire to the consultation.
3. Your Family Doctor may perform an examination which might include an electrocardiogram (ECG) or “heart tracing”.
4. Your Family Doctor may decide to refer you to see a Cardiologist or “heart specialist”
REMEMBER
If you reply “yes” to any of the questions above you should make an appointment to see your Family Doctor