SYNCOPE/FAINTING/PASSING OUT QUESTIONNAIRE

DATE: ________________

PATIENT NAME: _______________________

DOB: _________________

1. DID YOU INJURE YOURSELF WHEN YOU SUDDENLY LOST CONSCIOUSNESS? YES/NO
   IF YES, DESCRIBE YOUR INJURY:
   ____
2. DID YOU SUDDENLY LOOSE CONSCIOUSNESS DURING EXERCISE? YES/NO
3. DID YOU EXPERIENCE CHEST PAIN JUST BEFORE LOSING CONSCIOUSNESS? YES/NO
4. HAS THIS EVER HAPPENED TO YOU BEFORE? YES/NO
   IF YES, PLEASE EXPLAIN:
   ____
5. DO YOU HAVE HEART DISEASE? YES/NO
6. DO YOU HAVE A CLOSE RELATIVE (MOTHER, FATHER, BROTHER OR SISTER) WHO DIED OF SUDDEN CARDIAC ARREST? YES/NO
7. DO YOU HAVE EPILEPSY OR A SEIZURE DISORDER? YES/NO
8. DID YOU TAKE ANY MEDICATION OR DRINK ANY ALCOHOL WITHIN A HOUR OF YOUR EPISODE? YES/NO
9. DID YOU EXPREIENCE A DIFFUCULTY IN SPEECH OR A PROFOUND WEAKNESS ON ONE SIDE OF YOUR BODY JUST BEFORE OR AFTER YOUR EPISODE? YES/NO
10. HAVE YOU BEEN SIGNIFICANTLT SHORT OF BREATHIN THE HOURS TO DAYS BEFORE THIS EPISODE? YES/NO

11. DO YOU HAVE A HISTORY OF HEART FAILURE? YES/NO
12. DID YOU HAVE A PREMONITION JUST BEFORE THE EPISODE THAT YOU WERE BECOMING PROFOUNDLY LIGHTHEADED/ DIZZY? YES/NO
13. Do you smell things others don't smell? YES/NO
14. Have you ever had any significant head trauma? YES/NO
15. Do you have a history of concussions? YES/NO
16. Do you ever have Deja'VU? YES/NO
17. Do you ever have Jama'Vu? YES/NO
18. Do you have periods where you lose track of time? YES/NO
19. Do you have episodes of anxiety for no reason? YES/NO
20. Do you have vivid dreams? YES/NO
21. Do you have sleep paralysis? YES/NO
22. Do you have uncontrollable body movements? YES/NO