

ID 6_146_1_6

Date 18/03/2008

SMILE Test**Personal History (Bethesda questionnaire)**

	Freq	Seldom	No	I don't know
1. Have you ever felt dizzy, lightheaded or have you ever fainted during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Have you ever felt an irregular or fast heart beat during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Have you ever felt short of breath during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had chest pain during or after exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. Do you tire faster than your friends during exercise?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been told that you have a heart murmur?	<input type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>
7. Have you ever been told that you have high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
8. Have you had a serious viral or bacterial infection within the last month?	<input type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>
9. Are you taking any medication, dietary supplements, caffeine or nicotine now or in the recent past?	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Family History (Bethesda questionnaire)

	Yes	No	I don't know	
1. Has any family member or relative died of heart problems or sudden death?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
2. Has any family member or relative had a significant disability from heart disease?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
3. Has any family member or relative been told they have a serious heart dysrhythmia?	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
4. Has any of your relative ever have any of the following conditions?		<input checked="" type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Hypertrophic cardiomyopathy	<input type="checkbox"/> Coronary artery anomalies	<input type="checkbox"/> Arrhythmogenic right ventricular cardiomyopathy	<input type="checkbox"/> Long QT syndrome	<input type="checkbox"/> Marfan syndrome

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Physical Examination

Birthdate	<input type="text" value="19/12/1987"/>	Sex	<input type="text" value="Male"/>
Height (cm)	<input type="text" value="180"/>	Weight (Kg)	<input type="text" value="74"/>
Resting HR (bpm)	<input type="text"/>	Stress HR (bpm)	<input type="text"/>

RhythmBlood Pressure (mmHg) /

Precordial auscultation	None	Murmurs	Clicks	Other heart sound
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Sitting	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Supine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Physical stigmata of Marfan SyndromeNotes
Sports ActivitySport Training hours/week Competition Notes
Select ECG

Select ECG for this SMILE test

Select an optional ECG without arrhythmias for this SMILE test

SMILE Test Results

Title:

Standardised pre-competitive screening of athletes in some European and African countries: The SMILE study.

Journal:

Internal and Emergency Medicine.

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