Congenital Heart Surgeons' Society Data Center: XXX-XXX FOLLOW UP FORM YEAR 20XX

IDENTIFYING & PERSONAL HEALTH INFORMATION (PAGE 1&2) WILL BE STORED SEPARATELY FROM THE QUESTIONNAIRES AND KEPT PRIVATE & CONFIDENTIAL

Name:			
INFORMATION PREVIOUSLY GATHERED. PLEASE UPDATE OR CORRECT			
Current Address:			
Telephone Number:			
E-mail:			
Updated Address: (if applicable)			
Alternate Number:		☐ Mobile OR	☐ Work
Alternate Number:		☐ Mobile OR	☐ Work

Do you currently live with your parent(s)/guardian(s)? ☐ YES ☐ NO

Please list friends and/or relatives **NOT** living in your household that we may contact if we cannot locate you (e.g., change of address and/or telephone number).

When we contact them, we will ask them to provide us with your updated contact information (e.g., new address and/or telephone number) if they can.

NOTE: We will **NOT** be asking them to complete the follow-up form/questionnaires on your behalf.

You may provide up to 3 people:

Name _____ Relationship _____

Telephone Number: _____ Mobile/Work Number: _____

Name _____ Relationship _____

Telephone Number: _____ Mobile/Work Number: _____

Name _____ Relationship _____

Telephone Number: _____ Mobile/Work Number: _____

PLEASE COMPLETE BOTH SIDES OF THIS PAGE

PLEASE COMPLETE AND RETURN TO:
CHSS Data Center
The Hospital for Sick Children
555 University Ave., Rm. 4433, Black Wing
Toronto, ON M5G 1X8, Canada
Toll Free: 1-866-477-2477
Fax: (416) 813-8776

HEALTHCARE PROVIDER CONTACT INFORMATION

Name of your Cardiologist _____

Institution/Hospital Name _____

Street Address _____

City, State/Province, ZIP/Postal Code _____

Telephone Number: _____ Fax Number: _____

Name of your Family Doctor _____

Street Address _____

City, State/Province, ZIP/Postal Code _____

Telephone Number: _____ Fax Number: _____

1. Since **<DATE>** have you:

a) Had any **operations, catheterizations or "balloon" procedures**? YES ☐ NO ☐ If YES, please list

DATE (MM/DD/YYYY)	HOSPITAL NAME City, State/Province	OPERATION
☐☐/☐☐/☐☐☐☐		
☐☐/☐☐/☐☐☐☐		

b) Had any **echocardiograms**? YES ☐ NO ☐ If YES, please include reason (e.g. routine follow up, because of symptoms, or other reason)

DATE (MM/DD/YYYY)	HOSPITAL NAME City, State/Province	REASON
☐☐/☐☐/☐☐☐☐		
☐☐/☐☐/☐☐☐☐		

c) Been **hospitalized** for any other reason? YES ☐ NO ☐ If YES, please list reason

DATE (MM/DD/YYYY)	HOSPITAL NAME City, State/Province	REASON
☐☐/☐☐/☐☐☐☐		

I (participant name), _____, give permission for the CHSS Data Center to obtain copies of medical reports relating to my heart procedures. I understand that all the information provided will be kept confidential.

Signature: _____ Date Signed: _____

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GENERAL QUESTIONNAIRE **DATE COMPLETED:** ☐☐/☐☐/☐☐☐☐
(MM/DD/YYYY)

1. How has your health been over the past year?

   ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. Your current **height** _____ and **weight** _____

3. List all of your current medications: _____

   _____

4. Do you have an artificial heart pacemaker? YES ☐ NO☐

   If YES, date of first placement: ☐☐/☐☐/☐☐☐☐
   (MM/DD/YYYY)

5. During the past year, have you had any of the following symptoms?

   a. Chest Pain YES ☐ NO ☐

   b. Fainting YES ☐ NO ☐

   c. Palpitations YES ☐ NO ☐

6. Employment? ☐ I am a part-time student ☐ I am a full-time student ☐ I am not enrolled in school
   ☐ I am working part-time ☐ I am working full-time ☐ I am not currently working
   ☐ I am on disability ☐ Other (please specify): _____

7. Who do you see for your heart check-ups? ☐ Cardiologist ☐ Family Doctor ☐ Pediatrician ☐ No One
   ☐ Other (please specify): _____

8. How long ago was your last heart check-up? ☐☐ months **OR** ☐ year(s)

9. Please complete the attached questionnaires: PedsQL™ Quality of Life and Cardiac Module.
   (**PLEASE DO NOT WRITE YOUR NAME ON THE QUESTIONNAIRES**)

Thank you very much for your participation. Is there any additional information you want to share with us about your overall health?

_____

_____

_____

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STUDY #:

STUDY # will be indicated by CHSS Data Center upon receipt of this completed page/form