**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:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
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</table>

**Telephone Number:**

- [ ] Mobile  OR  [ ] Work

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<th>Name</th>
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</table>

**Telephone Number:**

- [ ] Mobile  OR  [ ] Work

**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

[Adult – Subsequent Follow Up] Version Date: 22 October 2015  

**FOLLOW-UP #:**
**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 your last *CHSS Data Center* follow up <DATE> have you:

   a) Had any operations, catheterizations or “balloon” procedures? **YES** □ **NO** □ If YES, please list

<table>
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<tr>
<th>DATE (MM/DD/YYYY)</th>
<th>HOSPITAL NAME City, State/Province</th>
<th>OPERATION</th>
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   b) Had any echocardiograms? **YES** □ **NO** □ If YES, please include reason (e.g. routine follow up, because of symptoms, or other reason)

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<th>DATE (MM/DD/YYYY)</th>
<th>HOSPITAL NAME City, State/Province</th>
<th>REASON</th>
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   c) Been hospitalized for any other reason? **YES** □ **NO** □ If YES, please list reason

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<tr>
<th>DATE (MM/DD/YYYY)</th>
<th>HOSPITAL NAME City, State/Province</th>
<th>REASON</th>
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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: [ ]

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: [ ]

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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[Adult] Version Date: 22 October 2015

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

FOLLOW-UP #: