

## **Table 1: Key Elements of the Medical History**

### ***General background:***

- Family history of sudden death, congenital arrhythmogenic heart disease or fainting
- Previous cardiac disease
- Neurological history (Parkinsonism, epilepsy, narcolepsy)
- Metabolic disorders (diabetes, etc.)
- Medication (antihypertensive, antianginal, antidepressant agent, antiarrhythmic, diuretics and QT prolonging agents)
- (In case of recurrent syncope) Information on recurrences such as the time from the first syncopal episode and on the number of spells

### ***Regarding loss of consciousness events***

- When did they start
- Any precipitating features
- How many, how often
- Any injury, what kind
- Any witnesses, what did they report

### ***Circumstances just prior to each attack***

- Position before event and any change in posture (supine, sitting or standing)
- Activity (rest, change in posture, during or after exercise, during or immediately after urination, defecation, cough or swallowing);
- Predisposing factors (e.g., crowded or warm places, prolonged standing, postprandial period) and of precipitating events (e.g., fear, intense pain, neck movements);

### ***Questions about onset of attack:***

- Nausea, vomiting, abdominal discomfort, feeling of cold, sweating, aura, pain in neck or shoulders, blurred vision, dizziness

***About each attack (patient and eyewitness):***

- Way of falling (slumping or kneeling over), skin colour (pallor, cyanosis, flushing), duration of loss of consciousness, breathing pattern (snoring), movements (tonic, clonic, tonic-clonic or minimal myoclonus, automatism) and their duration, onset of movement in relation to fall, tongue biting;

***End of attack:***

- Nausea, vomiting, sweating, feeling of cold, confusion, muscle aches, skin colour, injury, chest pain, palpitations, urinary or faecal incontinence