

Athlete PHE Form

MEDICAL HISTORY

Demographic

Personal Information

Last Name _____ First Name _____
 Address: Street _____ City _____ Region _____
 Post Code _____ Country _____
 Preferred Language: _____
 Birthdate: yyyy_____/mm_____/dd_____
 Sex (M/F): _____
 Phone: Home _____ Mobile _____
 Emergency Contact 1: Name _____ Relationship _____ Phone _____
 Emergency Contact 2: Name _____ Relationship _____ Phone _____
 Health Care Insurance (company number): _____
 Family Physician (name, phone number): _____

Background

The following questions ask for information regarding your personal background

What is your main sport? (sport, event/position): _____

Have you participated in other sports in the past (include those sports you have done competitively)? No Yes : _____

What is your ethnic origin?: _____

Do you have any religious convictions that could affect your medical treatment? No Yes

When was the last time you had a complete physical examination?: _____

Have you ever failed a pre-participation examination for sports, or has your doctor ever stopped you from participating in sports for any reason? No Yes

In total, how many days have you missed practice or competition in the past year because of injury or illness?: _____

Heart

Have you ever had any of the following heart or circulation related problems?:

Chest pain, discomfort, tightness or pressure with exercise? No Yes

Unexplained fainting or near fainting or passed out for no reason DURING or AFTER exercise? No Yes

Excessive or unexplained shortness of breath, lightheaded, or fatigue with exercise? No Yes

Do you get more tired or short of breath more quickly than your friends during exercise? No Yes

Does your heart race or skip beats (irregular beats) during exercise? No Yes

Heart murmur, high blood pressure, high cholesterol, heart infection or inflammation, rheumatic fever, heart valve problems, or any other heart related problem? No Yes

Have you ever had an unexplained seizure? No Yes

Any tests for your heart (for example, ECG or EKG, echocardiogram)? No Yes

Breathing

Have you ever had any of the following respiratory or breathing problems:

Do you have asthma? No Yes

Do you have any other symptoms of respiratory (lung) disease including, wheezing, cough, postnasal drip, hay fever, or repeated flu like illness? No Yes

Do you cough, wheeze or have more difficulty breathing than you should during or after exercise? No Yes

Have you ever used asthma medication (such as an inhaler)? No Yes

Have you ever had bronchitis, pneumonia, tuberculosis, cystic fibrosis or other respiratory or other breathing problem? No Yes

Heat

The following questions are about exercise in the heat:

Have you ever become ill while exercising in the heat? No Yes

Have you ever been diagnosed with heat exhaustion, heat stroke or hyperthermia? No Yes

Do you get frequent muscle cramps while exercising? No Yes

Have you ever had electrolyte (salt) or fluid imbalance? No Yes

Medical

Do you have any ongoing medical conditions or illness? No Yes

Do you have, or have you ever had any symptoms of medical problems such as:

Infections mononucleosis (**mono**), flu like symptoms or viral illness within the past month? No Yes

Disease of the **ears** (infections, hearing loss, pain), **nose** (sneezing, itchy nose, sinusitis, blocked nose) or **throat** (sore throat, hoarse voice, swollen glands in the neck)? No Yes

Blood disorders such as anemia, low iron stores, sickle cell trait or sickle cell disease, abnormal bleeding or clotting disorder, blood clot (embolus), or other blood disorder? No Yes

Immune system including current infections, recurrent infections, HIV/AIDS, leukemia, or are you using any immunosuppressive medication? No Yes

Skin problems such as rashes, infections (fungus, herpes, MRSA) or other skin problems? No Yes

Kidney or bladder disease, blood in the urine, loin pain, kidney stones, frequent urination, or burning during urination? No Yes

Gastrointestinal disease including heartburn, nausea, vomiting, abdominal pain, weight loss or gain (> 5kg), a change in bowel habits, chronic diarrhea, blood in the stools, or past history of liver, pancreatic or gallbladder disease? No Yes

Nervous system including past history of stroke or transient ischaemic attack (TIA), frequent or severe headaches, dizziness, blackouts, epilepsy, depression, anxiety attacks, muscle weakness, nerve tingling, loss of sensation, muscle cramps, or chronic fatigue? No Yes

Metabolic or hormonal disease including diabetes mellitus, thyroid gland disorders, or hypoglycemia (low blood sugar)? No Yes

Infections such as meningitis, hepatitis (jaundice), or chicken pox? No Yes

Arthritis or joint pain, swelling and redness not related to injury? No Yes

Were you born without, or are you **missing** a kidney, an eye or any other organ? No Yes

An **injury** to the any internal organs such as your liver, spleen, kidney(s) or lung? No Yes

Have you ever had **surgery**? (explain) No Yes

Do you get motion sickness (car, air or sea sickness)? No Yes

Do you have any other medical problems? No Yes

Family

Do any of your family members have a history of any of the following conditions (in male relatives < 55 years, female relatives < 65 years):

Sudden death for no apparent reason (including drowning, unexplained car accident, or sudden infant death syndrome)? No Yes

Unexplained fainting, seizures, or near drowning? No Yes

Died before age 50 due to heart disease? No Yes

Disability or symptoms from heart disease before age 50? No Yes

Other heart problems including electrical problems (arrhythmia) or heart enlargement, cardiomyopathy, heart surgery, pacemaker or defibrillator? No Yes

High blood pressure or high blood cholesterol? No Yes

Marfan's Syndrome? No Yes

Bleeding disorder, Sickle cell trait or sickle cell disease? No Yes

Tuberculosis or Hepatitis? No Yes

Anaesthetic reaction or problem? No Yes

Other condition such as stroke, diabetes, cancer, arthritis (describe)? No Yes

Are you unsure of your family history? No Yes

Medications

The following questions are about medications and supplements you are taking, or have taken in the past month:

Medications that have been prescribed by a doctor (include insulin, allergy shots or pills, sleeping pills, anti-inflammatory medications etc.)? No Yes

Non-prescription medications (include pain killers, anti-inflammatories, etc.)? No Yes

Vitamin or mineral **supplements** or herbal medicines? No Yes

Other substance to improve your athletic performance (include substances like creatine, weight gain products, amino acids, etc.)? No Yes

Have you ever been offered or encouraged to use **banned performance enhancing drugs**? No Yes

Allergies

Do you have any allergies to:

Medication? No Yes

Anything else, such as foods, pollens, stinging insects, any plant material or any animal material? No Yes

Immunization

Indicate which immunizations you have received:

Tetanus / Diphtheria (Td or Tdap)? No Yes Last shot? _____

Measles / Mumps / Rubella (2 shots)? No Yes

Chicken Pox (Varicella)? No Yes

Meningitis (Menimune or Menactra)? No Yes

Hepatitis A (2 shots)? No Yes

Hepatitis B (3 shots)? No Yes

Malaria? No Yes

Have you had a TB Test (PPD)? No Yes Result? _____

Have you had any other immunizations? No Yes Explain: _____

Female

These questions are for females only:

Have you ever had a menstrual period? No Yes

What was your age at your first menstrual period?: _____

Do you have regular menstrual cycles? No Yes

How many menstrual cycles did you have in the last year?: _____

When was your most recent menstrual period?: _____

Have you had a stress fracture in the past? No Yes

Have you ever been identified as having a problem with your bones such as low bone density (osteopenia or osteoporosis)? No Yes

Are you presently taking any female hormones (estrogen, progesterone, birth control pills)? No Yes

Have you ever had a sexually transmitted disease such as gonorrhea, syphilis, venereal warts, chlamydia or other infection? No Yes

Male

These questions are for males only:

Do you have two normal testicles? No Yes

Have you ever had a hernia or swelling around the testicle (varicocele, hydrocele)? No Yes

Have you ever had an injury to a testicle? No Yes

Have you ever had surgery for an undescended testicle, testicular injury or problem? No Yes

Have you ever had a sexually transmitted disease such as gonorrhea, syphilis, venereal warts, chlamydia or other infection? No Yes

Head & Neck

Have you ever had any of the following problems related to your head or neck?:

Eye injury, or other problems with your vision? No Yes

Headaches with exercise? No Yes

Have you ever had numbness, tingling or weakness in your arms and legs or been unable to move your arms or legs after being hit or falling? No Yes

Do you have, or have you been x-rayed for, neck (atlantoaxial) instability? No Yes

Have you had an injury to your teeth? No Yes

Do you have any other decayed, missing or filled teeth? No Yes

Do you have a dental prosthesis or appliance? No Yes

Have you had your wisdom teeth removed? No Yes

Injury

Have you ever had an injury to your face, head, skull or brain (including a concussion, confusion, memory loss or

headache from a hit to your head, having your "bell rung" or getting "dinged")?

No Yes

Have you had a problem or an injury like a sprain, strain, muscle or ligament tear, or tendonitis, broken bone, stress fracture or joint injury (that caused you to miss a practice or competition) to any of the following areas of your body?

Neck or spine (including a "stinger," or "whiplash,")

No Yes

Upper back (thoracic spine)

No Yes

Lower back (lumbar spine)

No Yes

Chest and ribs

No Yes

Shoulder area (including collar bone)

No Yes

Upper arm

No Yes

Elbow

No Yes

Lower arm (forearm)

No Yes

Wrist

No Yes

Hand or fingers

No Yes

Pelvis, groin or hip (including sports hernia)

No Yes

Thigh (including hamstrings and quadriceps)

No Yes

Knee

No Yes

Lower leg (calf or shin)

No Yes

Ankle

No Yes

Foot, heel or toes

No Yes

Other

Tests - If not already mentioned above, have you had any other tests, for any injury or condition including blood tests, X-rays, MRI, CT scan, Bone scan, Ultrasound, Electroencephalogram (EEG), Electromyogram (EMG), Nerve conduction studies (NCS), Electrocardiogram (ECG/EKG), Echocardiogram (Echo), Exercise stress test or other tests?

No Yes

Treatment - If not already mentioned above, have you ever received any of the following treatments for any condition?

Surgery?

No Yes

Been prescribed a brace, sling, cast, walking boot, orthotic, crutches or other appliance?

No Yes

Cortisone injection?

No Yes

Been prescribed other rehabilitation or therapy?

No Yes

Have you ever spent the night in a hospital or been admitted to a hospital as an inpatient or outpatient?

No Yes

Been referred to a medical specialist (cardiologist, neurologist or other medical person) for any condition not already mentioned?

No Yes

Equipment

Do you wear eye glasses or contact lenses?

No Yes

Are you currently using any of the following protective equipment?

No Yes

Do you use protective eyewear?

No Yes

Special equipment (pads, braces, etc.)?

No Yes

Mouth guard for sports?

No Yes

If you wear a helmet for sports, how old is it?

No Yes

Nutrition

The following questions are about nutrition:

Do you worry about your weight or body composition?

No Yes

Are you satisfied with your eating pattern?

No Yes

Are you a vegetarian?

No Yes

Do you lose weight to meet weight requirements for your sport?

No Yes

Does your weight affect the way that you feel about yourself?

No Yes

Do you worry that you have lost control over how much you eat?

No Yes

Do you make yourself sick when you are uncomfortably full?

No Yes

Do you ever eat in secret?

No Yes

Do you currently suffer or have you ever suffered in the past with an eating disorder?

No Yes

What is your current weight? ____

No Yes

How tall are you without shoes? ____

No Yes

Discuss

Do you have any other concerns that you would like to discuss with a doctor?

No Yes

Explain "YES" answers here:

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of athlete: _____

Signature of parents or legal representative (when needed): _____ Date _____

PHYSICAL EXAMINATION

Date of Examination: _____

Medical

	NORMAL	ABNORMAL (specify)
Appearance		
Eyes/ears/nose/throat		
Hearing		
Lymph nodes		
Heart		
Rhythm		
Heart sounds / murmurs in supine and standing		
Peripheral oedema		
Physical stigmata of Marfan's syndrome		
Blood vessels		
Peripheral pulses		
Delay in femoral pulses		
Vascular bruits (femoral)		
Varicose veins		
Blood Pressure in Sitting Position (after 5 minutes rest)		
Right arm		
Left arm		
Heart rate (after 5 Minutes rest)		
Lungs		
Abdomen		
Genitourinary (males only)		
Skin		
Eyes		
visual acuity (corrected/uncorrected)		
equal pupils		

Dental

DMF Index = Number of decayed, missing or filled teeth : _____

Oral Hygiene assessment: Good Fair Poor

Visible Oral Infection: No Yes

Presence of Worn, Broken or Loose/Mobile teeth: No Yes

Dental appliances (bridge, plate, braces or orthodontic appliance): No Yes

Musculoskeletal

Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		

Leg/ankle

Foot/toes

Investigations

12 Lead ECG

- Normal / no changes
- Common and training-related ECG changes
- UnCommon training-unrelated ECG changes

Details:

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Blood Tests

- Haemoglobin
- Haematocrit
- Erythrocytes
- Thrombocytes
- Leukocytes
- Ferritin
- Sodium
- Potassium
- Creatinine
- Cholesterol (total)
- LDL Cholesterol
- HDL Cholesterol
- Triglycerides
- Glucose
- C-reactive Protein

Other:

Clinical Evaluation Outcome

1 The athlete does not present apparent clinical contraindications to practice the following sport(s)
(specify): No • Yes •

If the answer to question 1 is "No", it is recommended that the athlete:

avoids participating:

- in training (explain) No • Yes •

- in competition (explain) No • Yes •

respects the following restrictions:

- during training (specify) No • Yes •

- during competition (specify) No • Yes •

undergoes further examinations (specify):

Examining physician

Name: _____ Phone Number: _____

Address: _____ Email _____