

# COMPREHENSIVE PPE 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 <input type="checkbox"/> | Yes <input type="checkbox"/> |
| What is your ethnic origin?   | _____ |                             |                              |
| Do you have any religious convictions that could affect your medical treatment?   |       | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 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 <input type="checkbox"/> | Yes <input type="checkbox"/> |
| In total, how many days have you missed practice or competition in the past year because of injury or illness?                                    | _____ |                             |                              |

#### Pre-Exercise Screening Questionnaire for COVID19

|  |                             |                              |
|--|-----------------------------|------------------------------|
| 1. Do you feel a sore throat?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 2. Do you feel cough and sputum production?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 3. Do you feel fatigue?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 4. Do you feel short of breath or difficulty breathing?                                      | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 5. Do you feel fever? (more than 37.8°C)   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 6. Have you had fever for more than three days? (more than 37.8°C)                           | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 7. Have you had any contact with anyone who has been diagnosed with or suspected of COVID19? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |

*The decision regarding COVID19 clearance is at the discretion of the medical practitioner.*

**If you answered YES** to 4 out of 7 questions, or question 6 and/or question 7, you should seek medical clearance and refrain from exercise until cleared.

**If you answered NO** to all question, you can be reasonably sure that you can exercise safely.

### Heart

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

|  |                             |                              |
|--|-----------------------------|------------------------------|
| Chest pain, discomfort, tightness or pressure with exercise?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Unexplained fainting or near fainting or passed out for no reason DURING or AFTER exercise?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Excessive or unexplained shortness of breath, lightheaded, or fatigue with exercise?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Do you get more tired or short of breath more quickly than your friends during exercise?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Does your heart race or skip beats (irregular beats) during exercise?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Heart murmur, high blood pressure, high cholesterol, heart infection or inflammation, rheumatic fever, heart valve problems, or any other heart related problem? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Have you ever had an unexplained seizure?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Any tests for your heart (for example, ECG or EKG, echocardiogram)?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |

### Heat

#### The following questions are about exercise in the heat:

|   |                             |                              |
|---|-----------------------------|------------------------------|
| Have you ever become ill while exercising in the heat?                          | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Have you ever been diagnosed with heat exhaustion, heat stroke or hyperthermia? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Do you get frequent muscle cramps while exercising?                             | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Have you ever had electrolyte (salt) or fluid imbalance?                        | No <input type="checkbox"/> | Yes <input type="checkbox"/> |

## Medical

Do you have any ongoing medical conditions or illness?

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

- |   |                             |                              |
|---|-----------------------------|------------------------------|
| Infections mononucleosis ( <b>mono</b> ), flu like symptoms or viral illness within the past month?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Disease of the <b>ears</b> (infections, hearing loss, pain), <b>nose</b> (sneezing, itchy nose, sinusitis, blocked nose) or <b>throat</b> (sore throat, hoarse voice, swollen glands in the neck)?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| <b>Blood disorders</b> such as anaemia, low iron stores, sickle cell trait or sickle cell disease, abnormal bleeding or clotting disorder, blood clot (embolus), or other blood disorder?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Immune system including current infections, recurrent infections, HIV/AIDS, leukaemia, or are you using any immunosuppressive medication?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| <b>Skin problems</b> such as rashes, infections (fungus, herpes, MRSA) or other skin problems?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| <b>Kidney or bladder disease</b> , blood in the urine, loin pain, kidney stones, frequent urination, or burning during urination?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| <b>Gastrointestinal disease</b> including heartburn, nausea, vomiting, abdominal pain, weight loss or gain (> 5kg), a change in bowel habits, chronic diarrhoea, blood in the stools, or past history of liver, pancreatic or gallbladder disease?                            | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| <b>Nervous system</b> 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 <input type="checkbox"/> | Yes <input type="checkbox"/> |
| <b>Metabolic or hormonal</b> disease including diabetes mellitus, thyroid gland disorders, or hypoglycaemia (low blood sugar)?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| <b>Infections</b> such as meningitis, hepatitis (jaundice), or chicken pox?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| <b>Arthritis</b> or joint pain, swelling and redness not related to injury?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Were you born without, or are you <b>missing</b> a kidney, an eye or any other organ?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| An <b>injury</b> to the any internal organs such as your liver, spleen, kidney(s) or lung?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Have you ever had <b>surgery</b> ? (explain)  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Do you get motion sickness (car, air or sea sickness)?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Do you have any other medical problems?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |

## 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 <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Unexplained fainting, seizures, or near drowning?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Died before age 50 due to heart disease?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Disability or symptoms from heart disease before age 50?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Other heart problems including electrical problems (arrhythmia) or heart enlargement, cardiomyopathy, heart surgery, pacemaker or defibrillator? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| High blood pressure or high blood cholesterol?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Marfan's Syndrome?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Bleeding disorder, Sickle cell trait or sickle cell disease?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Tuberculosis or Hepatitis?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Anaesthetic reaction or problem?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Other condition such as stroke, diabetes, cancer, arthritis (describe)?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Are you unsure of your family history?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |

## 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 <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Non-prescription medications (include pain killers, anti-inflammatories, etc.)?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Vitamin or mineral supplements or herbal medicines?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Other substance to improve your athletic performance (include substances like creatine, weight gain products, amino acids, etc.)?                | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Have you ever been offered or encouraged to use banned performance enhancing drugs?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |

## Allergies

Do you have any allergies to:

- |   |                             |                              |
|---|-----------------------------|------------------------------|
| Medication?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Anything else, such as foods, pollens, stinging insects, any plant material or any animal material? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |

## Immunization

Indicate which immunizations you have received:

- |                                      |                             |                              |                                 |
|--------------------------------------|-----------------------------|------------------------------|---------------------------------|
| Tetanus / Diphtheria (Td or Tdap)?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> | Last shot? <input type="text"/> |
| Measles / Mumps / Rubella (2 shots)? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |                                 |

|                                       |                             |                              |                               |
|---------------------------------------|-----------------------------|------------------------------|-------------------------------|
| Chicken Pox (Varicella)?              | No <input type="checkbox"/> | Yes <input type="checkbox"/> |                               |
| Meningitis (Menimune or Menactra)?    | No <input type="checkbox"/> | Yes <input type="checkbox"/> |                               |
| Hepatitis A (2 shots)?                | No <input type="checkbox"/> | Yes <input type="checkbox"/> |                               |
| Hepatitis B (3 shots)?                | No <input type="checkbox"/> | Yes <input type="checkbox"/> |                               |
| Malaria?                              | No <input type="checkbox"/> | Yes <input type="checkbox"/> |                               |
| Have you had a TB Test (PPD)?         | No <input type="checkbox"/> | Yes <input type="checkbox"/> | Result? <input type="text"/>  |
| Have you had any other immunizations? | No <input type="checkbox"/> | Yes <input type="checkbox"/> | Explain: <input type="text"/> |

### Female

These questions are for females only:

|  |                             |                              |
|--|-----------------------------|------------------------------|
| Have you ever had a menstrual period?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| What was your age at your first menstrual period? <input type="text"/>   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Do you have regular menstrual cycles?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| How many menstrual cycles did you have in the last year? <input type="text"/>  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| When was your most recent menstrual period? <input type="text"/>   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Have you had a stress fracture in the past?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Have you ever been identified as having a problem with your bones such as low bone density (osteopenia or osteoporosis)?     | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Are you presently taking any female hormones (estrogen, progesterone, birth control pills)?                                  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Have you ever had a sexually transmitted disease such as gonorrhoea, syphilis, venereal warts, chlamydia or other infection? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |

### Male

These questions are for males only:

|  |                             |                              |
|--|-----------------------------|------------------------------|
| Do you have two normal testicles?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Have you ever had a hernia or swelling around the testicle (varicocele, hydrocele)?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Have you ever had an injury to a testicle?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Have you ever had surgery for an undescended testicle, testicular injury or problem?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Have you ever had a sexually transmitted disease such as gonorrhoea, syphilis, venereal warts, chlamydia or other infection? | No <input type="checkbox"/> | Yes <input type="checkbox"/> |

### 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 <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Headaches with exercise?  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| 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 <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Do you have, or have you been x-rayed for, neck (atlantoaxial) instability?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Have you had an injury to your teeth?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Do you have any other decayed, missing or filled teeth?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Do you have a dental prosthesis or appliance?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Have you had your wisdom teeth removed?   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |

### 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 <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Upper back (thoracic spine)                           | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Lower back (lumbar spine)                             | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Chest and ribs  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Shoulder area (including collar bone)                 | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Upper arm   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Elbow   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Lower arm (forearm)                                   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Wrist   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Hand or fingers                                       | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Pelvis, groin or hip (including sports hernia)        | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Thigh (including hamstrings and quadriceps)           | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Knee  | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Lower leg (calf or shin)                              | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Ankle   | No <input type="checkbox"/> | Yes <input type="checkbox"/> |
| Foot, heel or toes                                    | No <input type="checkbox"/> | Yes <input type="checkbox"/> |

### 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?

No  Yes

### Surgery

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 eyeglasses 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?

How tall are you without shoes?

### 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 Details:
- Normal / no changes
  - Common and training-related ECG changes
  - Uncommon training-unrelated ECG changes

#### Blood Tests

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

\*Additional remarks of the physician may be attached as required.

### Clinical Evaluation Outcome

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)

- during competition (specify)

undergoes further examinations (specify):

### Examining physician

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Signature: \_\_\_\_\_

Stamp: \_\_\_\_\_