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 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?

Pre-Exercise Screening Questionnaire for COVID19

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

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 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

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?

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 anaemia, 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, leukaemia, 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 diarrhoea, 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 hypoglycaemia (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 / Diptheria (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?	No	Yes
Do you have regular menstrual cycles?	No	Yes
How many menstrual cycles did you have in the last year?	No	Yes
When was your most recent menstrual period?	No	Yes
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 gonorrhoea, 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? 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		
Lympth 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 Hygeine 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			

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):

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

Examining physician

Name: Address:

Phone Number: Email: