

Name: _____ **Sex:** M F **Age:** _____

Personal identification code: _____ **Address:** _____

Phone: _____ **E-mail:** _____

Sports club: _____ **Coach(es):** _____

Sport: _____

Training volume: _____ **times a week,** _____ **academic hours. Competitions per month** _____ **times.**

Where and when you had the last sports medicine related checkup: _____

Medicines: please name all prescriptions and over-the-counter medicines you currently use:

Please tick the appropriate box („yes“ or „no“) and explain „yes“ answers below.

Please circle the numbers of any questions you cannot answer.

General questions	Yes	No
1. Do you have any concerns you would like to discuss with a doctor?		
2. Has a doctor ever restricted or prohibited you from exercising for any reason?		
3. Do you have any chronic illness (e.g., diabetes, asthma, anemia, hepatitis, etc.)?		
4. Were you born without a kidney, eye, testicle (men), or any other organ, or has any organ been removed?		
5. Have you been hospitalized?		
6. Have you had surgery?		
Explanation:		
Heart health questions about you	Yes	No
7. Have you ever fainted or nearly fainted during exercise or after exercise?		
8. Have you felt discomfort, pain, or pressure in your chest during exercise?		
9. Have you experienced heart rhythm disturbances during exercise (e.g., palpitations, skipped beats, etc.)?		
10. Has a doctor ever told you that you have heart problems? If yes, please indicate: high blood pressure <input type="checkbox"/> heart murmur <input type="checkbox"/> high cholesterol <input type="checkbox"/> myocarditis <input type="checkbox"/> congenital heart disease <input type="checkbox"/> other:		
11. Has a doctor ever referred you for heart examinations (e.g., ECG, echocardiography)?		
12. Do you get tired significantly faster or experience more shortness of breath than your training partners?		
Explanation:		
Heart health questions about your family	Yes	No
13. Has anyone in your family (or relatives) had, before age 50, a heart attack, stroke, heart-related death, sudden death, or resuscitation due to cardiac arrest?		
14. Does anyone in your family have congenital heart problems, a pacemaker, or an implanted defibrillator?		
15. Has anyone in your family had unexplained fainting, seizures, or drowning?		
Explanation:		

Musculoskeletal questions	Yes	No
16. In the past year, have you had any injuries to bones, muscles, ligaments, or tendons that caused you to miss training or competitions?		
17. Have you had fractures (including stress fractures) or joint dislocations?		
18. Due to an injury, have you had X-rays, MRI or CT scans, injections, or surgery; or used a splint, brace/orthosis, or crutches?		
19. Do you regularly use an orthosis (support bandage) or any other support aid?		
20. Do you have any bone, muscle, or joint injury that bothers you?		
21. Is any of your joints painful, warm, swollen, or red?		
22. Has a doctor told you that you have arthritis or a connective tissue disease?		
Explanation:		
Questions about general health status	Yes	No
23. During exercise, do you have coughing, sneezing, breathing difficulty, or shortness of breath?		
24. Have you ever used an inhaler or asthma medication?		
25. Does anyone in your family have asthma?		
26. Do you have allergies (e.g., to medications, pollen, food, insects, etc.)?		
27. Do you have groin pain, a painful lump, or a hernia in the groin area?		
28. In the past year, have you had infectious mononucleosis?		
29. Do you have any skin conditions?		
30. Have you had a blow to the head (head injury) that resulted in confusion or memory loss?		
31. Have you had seizures or seizure disorders?		
32. During exercise, have you had headaches?		
33. After a blow or a fall, have you had numbness or weakness in your arms or legs lasting more than 24 hours, or an inability to move your arms/legs?		
34. When exercising in hot weather, have you felt unwell?		
35. During exercise, do you often have muscle cramps?		
36. Do you or any of your family members have anemia or another blood disorder?		
37. Have you had any vision problems or eye injuries?		
38. Do you wear glasses or contact lenses during exercise?		
39. Are you satisfied with your body weight?		
40. Are you trying to, or has someone advised you to, lose or gain weight?		
41. Are you on a special diet or do you avoid certain foods?		
42. Have you had an eating disorder?		
Explanation:		
FOR WOMEN ONLY	Yes	No
- do you have menstrual periods?		
- do you have a menstrual period every month?		
- at what age did you have your first menstrual period?		

I confirm that I have answered all questions honestly, and I consent to the use of my/my child's/my dependent's data in accordance with the European Union General Data Protection Regulation (GDPR) in force since 25/05/2018.

I consent to the healthcare service provided to me/my child.

Date: ____/____/____

Athlete's signature _____ Parent/guardian name and signature _____