Questionnaire medical screening

Name:……..…… **Date of birth**: …-…-……. **Date**: …-…-……..
Education:……

Do you agree that your general practitioner receives a report of this screening (if applicable)? ……..Yes/ No

- Sport(s): ……..frequency:…../week, duration:…..hours.
- ……..frequency:…../week, duration:…..hours
- ……..frequency:…../week, duration:…..hours.
- (Old) sports injuries: ……
- ……
- Other medical history:……
- ……
- Smoking: Yes/No, if so: average of … per day
- Alcohol: Yes/No, if so: average of… per day
- Medication (actual):…….
- Medication (last 2 years):……
- Allergies:……..

General questions

- Have you ever been treated by a medical specialist/psychologist? ..... Yes/ No
- Have you ever been seriously or chronically sick/ill? ..... Yes/ No
- Did you ever have surgery? ..... Yes/ No
- Did you ever have an accident?..... Yes/ No
- Did you ever feel unhealthy or less fit? ..... Yes/ No
- Have you ever had overtraining syndrome?.....Yes/ No
- Do you have sleeping problems? .....Yes/ No
- Do you have a special diet? (for example vegetarian)? ..... Yes/ No
- Do you have intolerances to certain foods?..... Yes/ No
- Are you satisfied with your weight?..... Yes/ No
- Have you ever lost or gained a lot of weight? ..... Yes/ No
- Have you ever had eating problems, now or in the past?..... Yes/ No
- Did/do you suffer from stomach ache / sour burn?.....Yes/ No
- Did/do you suffer from diarrhoea / problems with your stool?.....Yes/ No
- Did/do you suffer from skin diseases?..... Yes/ No
- Did/do you suffer from frequent headaches?..... Yes/ No
- Did/do you suffer from visual problems?..... Yes/ No
- Did/do you suffer from deafness / loss of hearing?.....Yes/ No
- Have you ever had a (stress/fatigue) fracture?..... Yes/ No
- Do you use braces, orthotics or tape during exercise?..... Yes/ No
- Have you been treated by a physiotherapist in the last year?..... Yes/ No

For women

- Do you have irregular periods? ..... Yes/ No
- Did you ever had no menstrual period for more than three consecutive months? ..... Yes/ No
- Was your first menstrual period after age of 15? ..... Yes/ No
- Do you use birth control pills?..... Yes/ No

Cardiovascular screening

- Did you ever loose consciousness during or immediately after exercise?..... Yes/ No
- Did you ever have chest pain or discomfort?..... Yes/ No
- Have you ever had chest tightness, shortness of breath or excessive coughing during or after exercises, in such a way that this effort was made difficult? ……. Yes/ No
- Have you ever been treated for asthma?..... Yes/ No
- Did you or do you suffer from epilepsy?..... Yes/ No
- Did you ever get the advice to stop sports because of a heart disease?..... Yes/ No
- Did you or do you suffer from high blood pressure?..... Yes/ No

- Did you or do you suffer from high cholesterol?.. Yes/ No
- Have you ever felt dizzy during exercise?... Yes/ No
- Did you ever have palpitations while resting or during exercise.. Yes/ No
- Do you notice sometimes extreme fatigue that does not fit your regular exercise level?................ Yes/ No
- Did you or do you suffer from a heart murmur?... Yes/ No
- Did you or do you suffer from arrhythmia?.. Yes/ No
- Did you or do you suffer from other heart problems?.. Yes/ No
- Have you recently been diagnosed with a serious (viral) infection?..Yes/ No
- Have you ever had acute rheumatic fever?.. Yes/ No

Family history

Has anyone in your family*:

- died suddenly and unexpectedly? ……………………………………………………………... Yes/ No
- been treated for recurrent fainting?.. Yes/ No
- had unexplained seizure problems?... Yes/ No
- had unexplained drowning while swimming?.. Yes/ No
- had unexplained car accident?... Yes/ No
- been diagnosed with cardiomyopathy?... Yes/ No
- had a heart attack or angina?.. Yes/ No
- had angioplasty or heart surgery? ....Yes/ No
- had heart transplantation?... Yes/ No
- had pacemaker or defibrillator implanted?... Yes/ No
- been treated for irregular heart beat?.. Yes/ No
- Has anyone in your family experienced sudden infant death (cot death)?......................................Yes/ No
- Has anyone in your family been told they have Marfan syndrome?..Yes/ No

* among family are close family, but it also includes nephews, nieces and second cousins

Date: …-…-……..

Name :……………………….……………………… **Signature:**……………………………………………………………

Please do NOT fill in the information below

Length: ……………cm	Weight: ……………kg	BMI: ……………..kg/m^2
Sum of skin folds: ………….mm	Fat percentage:………%	
Vision right (VOD):………	left (VOS):………….	both (VODS):………….
Lung function FVC: ……..L (….%pred)	FEV1: ……..L (…..%pred)	Tiff: …..%
Blood pressure: …......mmHg	Urine:…………………….	Hb:………… mmol/L

Physical examination:

Heart:………………………………………………………
……………………………………………………….……..
Lungs:………………………………………………………
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Abdomen:…………………………………………………..
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Arteries:……………………………………………….....
Marfan stigmata? ....
Other:………………………………………………………
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Musculoskeletal:……………………………………
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