## Questionnaire medical screening

<table>
<thead>
<tr>
<th>Name: ..................................................................................</th>
<th>Date of birth: …-…-…..</th>
<th>Date: …-…-…..</th>
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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.
- (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
• Did 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:................................................................. Musculoskeletal:..............................................
Lungs:.................................................................................................................................
Abdomen:..........................................................................................................................
Arteries:..............................................................................................................................
Marfan stigmata?.................................................................................................................
Other:....................................................................................................................................

.................................................................