Athlete PHE 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?: _____

Heart

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

Chest pain, discomfort, tighness 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 ❑

Breathing

Have you ever had any of the following respiratory or breathing problems:

Do you have asthma? No ❑ Yes ❑
Do you have any other symptoms of respiratory (lung) disease including, wheezing, cough, postnasal drip, hay fever, or repeated flu like illness? No ❑ Yes ❑
Do you cough, wheeze or have more difficulty breathing than you should during or after exercise? No ❑ Yes ❑
Have you ever used asthma medication (such as an inhaler)? No ❑ Yes ❑
Have you ever had bronchitis, pneumonia, tuberculosis, cystic fibrosis or other respiratory or other breathing problem? 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? No ❑ Yes ❑

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 anemia, 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, leukemia, 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 diarrhea, 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 hypoglycemia (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 defibulator?	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?: _____		
Do you have regular menstrual cycles?	No ❑	Yes ❑
How many menstrual cycles did you have in the last year?: _____		
When was your most recent menstrual period?: _____		
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 gonorrhea, 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?		
Surgery?	No ❑	Yes ❑
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 eye glasses 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? ___	No ❑	Yes ❑
How tall are you without shoes? ___	No ❑	Yes ❑

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

- ❑ Normal / no changes
- ❑ Common and training-related ECG changes
- ❑ UnCommon training-unrelated ECG changes

Details:

Blood Tests

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

Other:

Clinical Evaluation Outcome

The athlete does not present apparent clinical contraindications to practice the following sport(s):

- ❑ Yes; Specify: _____
- ❑ No; If the answer to question 1 is "No", it is recommended that the athlete:

1. avoids participating:
   - ❍ in training (explain): _____
     _____
   - ❍ in competition (explain): _____
     _____
2. respects the following restrictions:
   - ❍ during training (specify): _____
     _____
   - ❍ during competition (specify): _____
     _____
3. undergoes further examinations (specify): _____
   _____

Examining physician

Name: _____ Phone Number: _____

Address: _____ Email _____