Sport Medical Questionnaire

Academy for Physical Education and Sports and Health Management
University Sport Medical Centre Groningen
Groningen, The Netherlands

Surname: _____ Male / Female*

First name:_____ Married / Not married*

Date of birth ___day/___month/ _____year

Adress: _____

Postal code: _____ City: _____

Telephone number _____

Name health insurance company (HIC): _____

Policy number HIC: _____

Nationality: _____

Passport number:_____

Name general practitioner (GP): _____ City GP:_____

Type of Sport test?

- ☐ Preventive cardiological screening (€65,-)
- ☐ Basic sport test (€90,-)
- ☐ Maximal sport test (€125,-)
- ☐ Maximal sport test with VO2max (€175,-)
- ☐ Mandatory test before starting with your education (ALO/SGM) (€75,-)

Please answer the questions below as correctly as possible. Please elaborate when asked. Not applicable questions may be skipped.

1. What is the reason for this Sport Medical Test?
   ……
   ……
   ……

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Medical History:

2. Have you ever been operated on? Yes / No
   When **YES**, please specify:
   ……
   ……
   ……

3. Have you ever been diagnosed with a medical illness or disease? Yes / No
   When **YES**, please specify:
   ……
   ……
   ……

4. Have you ever had any fractures or other physical injuries? Yes / No
   When **YES**, please specify:
   ……
   ……
   ……

5. Have you ever been hospitalised? Yes / No
   When **YES**, please specify:
   ……
   ……
   ……

6. Do you use any medications? Yes / No
   When **YES**, please specify:
   ……
   ……
   ……

7. Have you ever had any previous Medical testing? Yes / No
   When **YES**, please specify:
   ……
   ……
   ……

8. Have you ever been medically disapproved? Yes / No
   When **YES**, please specify:
   ……
   ……
   ……

Hart, lungs and cardiovascular system:

9. Have you ever fainted or passed out when exercising? Yes / No
10. Do you ever have chest tightness? Yes / No
11. Does running ever cause chest tightness? Yes / No
12. Have you ever had chest tightness, cough, wheezing, which made it difficult for you to perform in sports? Yes / No

13. Have you ever been treated/ hospitalized for asthma? Yes / No
14. Have you ever had a seizure? Yes / No
15. Have you ever been told that you have epilepsy? Yes / No
16. Have you ever been told to give up sports because of health problems? Yes / No
17. Have you ever been told you have high blood pressure? Yes / No
18. Have you ever been told you have high cholesterol? Yes / No
19. Do you have trouble breathing or do you cough during or after activity? Yes / No
20. Have you ever been dizzy during or after exercise? Yes / No
21. Have you ever had chest pain during or after exercise? Yes / No
22. Do you have or have you ever had racing of your heart or skipped heartbeats? Yes / No
23. Do you get tired more quickly than your friends do during exercise? Yes / No
24. Have you ever been told you have a heart murmur? Yes / No
25. Have you ever been told you have a heart arrhythmia? Yes / No
26. Do you have any other history of heart problems? Yes / No
27. Have you had a severe viral infection within the last month? Yes / No
28. Have you ever been told you had rheumatic fever? Yes / No
29. Do you have any allergies? Yes / No
30. Have you routinely taken any medication in the past two years? Yes / No

Cardiovascular Family History:

31. Has anyone in your family less than 50 years old:
    - Died suddenly and/or unexpectedly? Yes / No
    - Has been diagnosed with a heart disease? Yes / No
    - Has an inheritable heart disease? 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
    - Had heart transplantation? Yes / No
    - Had pacemaker or defibrillator implanted? Yes / No
    - Been treated for irregular heart beat? Yes / No
    - Had heart surgery? Yes / No
    - Has Sickle cell disease Yes / No

32. Has anyone in your family experienced sudden infant death (cot death)? Yes / No
33. Has anyone in your family been told they have Marfan syndrome? Yes / No

Muscle, tendon and joints:

34. Do you have any complaints to your muscle(s), tendon(s) and/or joint(s)? Yes / No
    When **YES**, please specify:
    ……
    ……
    ……

35. Have you had in the past any (regularly) complaints to your muscle(s), tendon(s) and/or joint(s)? Yes / No
When **YES**, please specify:
……
……
…….

36. Have you ever had a sports injury? Yes / No
When **YES**, please specify:
……
……
…….

Menstrual issues:

37. Do you have menstrual complaints? Yes / No
38. Do you take any birth control medication? Yes / No

Diet:

39. Are you on any special diet? Yes / No
When **YES**, please specify:
……
……
…….

40. Do you take any nutritional supplement? Yes / No
When **YES**, please specify:
……
……
…….

41. What is your average weekly alcohol consumption (drinks/week)?
……

Sport participation:

42. What sport(s) do you and/or have you participated in, in the last 10 years?

Sport	Years	Hours/week (average)	Competitive (Yes/No)	Remarks

43. Have you ever been over trained? Yes / No
When **YES**, please specify:
……
……
……

44. What are your best sports result (championships / personal record / etc.)
……
……
……

45. What are your current sport goals?
……
……
……

46. How does your current average weekly sports participation look like?

	Sport	**Hours**	**Competitive / Training**	**Goal**	**Remarks**
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					

Privacy:

47. Do you have any objections to a written result of the Medical test being send to your General Practitioner? Yes / No
48. Do you have any objections to your data of this Medical test to be used **anonymously** for medical research? Yes / No

Remarks:
……
……
……
……
……

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I hereby declare to have filled out this questionnaire truthfully.

Date: ….. / …… / …….
Place: ……..

Signature: …….