Sporto+ medica

Sports Medical Health Survey Questionnaire for Young Athletes ESMF-1

First name: _____

Last name: ___

Gender: M ☐ F ☐

Age: _____ **years**

Personal identification code: _____

Address: _____

Phone: _____

E-mail: _____

Sport(s): _____

Coach(s): _____

Sports school/club: _____

Training load: _____ **times a week,**

total _____ **academic hours.**

Competitions _____

times a month.

When and where did the previous sports medical health examination take place: _____

School: _____

Medications: Please mark any prescription or over-the-counter medicines and supplements you are currently taking:

_____

Please mark the appropriate YES or NO box and explain your YES answers in the explanations line. Please circle around the numbers of the questions you don't know how to answer.

General questions	YES	NO
1. When was the last time you got sick with a fever?		
2. Do you have any concerns about which you would like to consult a doctor?		
3. Has your doctor ever restricted or prohibited you from sporting activities for any reason?		
4. Do you suffer from any chronic diseases (e.g. diabetes, asthma, anemia, hepatitis, etc.)?		
5. Were you born without one kidney, eye, testicle (men) or any other organ, or have you had an organ removed?		
6. Have you been hospitalized?		
7. Have you had surgery?		
Explanation:		
Heart Health Questions About You	**YES**	**NO**
8. Have you fainted or been on the verge of fainting **during or after sporting activities**?		
9. Have you felt any discomfort, pain or chest tightness **during sporting activities**?		
10. Have you had any cardiac arrhythmias **during sporting activities** (e.g. palpitations, your heart has skipped beats, etc.)?		
11. Has your doctor said that you have heart problems? If so, please indicate: ☐ high blood pressure ☐ cardiac murmur ☐ high cholesterol ☐ myocarditis ☐ congenital heart disease ☐ other: _____		
12. Has your doctor ever referred you for heart examinations (e.g. ECG, echocardiography)?		
13. Do you get tired much faster or do you experience more shortness of breath than your training partners?		
Explanation:		
Heart health questions about your family	**YES**	**NO**
14. Have any of your family members or relatives experienced heart attack, brain stroke, heart-related deaths, sudden deaths or resuscitation due to cardiac arrest before the age of 50?		
15. Does anyone in your family have congenital heart problems, a pacemaker or an implanted defibrillator installed?		
16. Has anyone in your family experienced fainting, seizure or drowning of unclear cause?		
Explanation:		

Questions about the support-movement system	YES	NO
17. Have you had any injuries to your bones, muscles, ligaments or tendons in the last year that have caused you to be absent from training or competitions?		
18. Have you had fractures (cracks), fatigue fractures or joint sprains?		
19. Have you been subjected to X-rays, MRI or CT examinations, injections, surgeries due to the injury; have you used splints, orthoses, crutches?		
20. Do you regularly use orthosis (support bandage) or any other means of support?		
21. Do you have a bone, muscle or joint injury that bothers you?		
22. Does any of your joints hurt, get hot, swollen or redden?		
23. Has your doctor told you that you have joint inflammation or connective tissue disease?		
Explanation:		
Questions about the general state of health	**YES**	**NO**
24. Do you experience coughing, sneezing, difficulty breathing or shortness of breath **during sporting activities**?		
25. Have you ever used an inhaler or asthma medicine?		
26. Does anyone in your family have asthma?		
27. Do you have an allergy to medicines, pollen, food, insects, etc.?		
28. Do you have groin pain or a painful formation or a hernia in the groin area?		
29. Have you suffered from infectious mononucleosis in the past year?		
30. Do you have any skin conditions?		
31. Have you suffered any blows to the head area (head trauma) that have resulted in a blurred consciousness or memory loss?		
32. Have you had any seizures/diseases with convulsions?		
33. Have you had a headache **during sporting activities**?		
34. After a strike or a fall, have you experienced a feeling of numbness or weakness in your arms or legs or an inability to move your arms and legs for **more than 24 hours**?		
35. Do you feel unwell during sporting activities in hot weather?		
36. Do you often experience muscle cramps **during sporting activities**?		
37. Do you or a member of your family have anemia or other blood disease?		
38. Have you had vision problems or eye injuries?		
39. Do you wear glasses or contact lenses during sporting activities?		
40. Are you satisfied with your weight?		
41. Are you trying or has anyone advised you to lose or gain weight?		
42. Are you on a special diet or do you avoid certain foods?		
43. Do you have a history of an eating disorder?		
Explanation:		
FOR WOMEN ONLY	**YES**	**NO**
44. Do you have menstruation?		
45. Does menstruation occur monthly?		
46. At what age did you experience your first menstruation?		

With my signature, I confirm that I have answered all questions honestly on both pages of the questionnaire, agree to the health care provided to me / my child, and agree to the processing of my / my child's sensitive personal data for the purpose of providing health care services in accordance with privacy policy, the terms of which are set out in www.sportomedica.ee

If the doctor does not issue the summary of the medical examination on the same day, it will be sent in encrypted form to the parent's e-mail. To do this, please indicate:

Parent's personal identification code_____

and email _____

Date: _____

Athlete's signature _____

Name and signature of parent/guardian_____

_____