Questionnaire medical screening

H+ Antoniushove MC

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 seriously or chronically sick/ill ? ..... Yes/No
- Have you ever been treated by a medical specialist/psychologist ? ..... 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 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 after rage of 15 ?..... Yes/No
- Was your first menstrual period after age of 15?..... Yes/No
- Do you use birth control pills?..... Yes/No

Cardiovasculair screening

- Did you ever loose consciousness during or immediately after exercise ?..... Yes/No
- Did you ever have 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 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 whit cardiomyopathy ?..... … Yes/No
- had a heart attack or angina ?..... Yes/No
- had angioplasty or heart surgery ?..... Yes/No
- had a heart transplantation ?..... Yes/No
- had pacemaker or defibrillator implanted ?..... Yes/No
- been treated for irregular heart beat ?..... Yes/No
- has anyone in your family been experienced sudden infant death (cor 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

Lenght :……..cm Weight :……..kg BMI :……..kg/m2

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

Shuttle run : …… trap

Physical examination :

Heart :……. Musculoskeletal…….

……. …….

Lungs :…… …….

……. …….

Abdomen…… ……..

Arteries: ……. ……..

Marfan stigmata ?..... …….

Other : …… …….

……. …….