EFSMA PPE QUESTIONNAIRE

ATHLETES NAME:_____BIRTH DATE:_____AGE:____GENDER: M /F
ADDRESS:

_____

TELEPHONE: _____
SPORTS: _____

GENERAL QUESTIONS (incl. vaccination, allergic diseases,…)

Has a doctor ever denied or restricted your participation in sports for any reason?	YES	NO	?
Do you have an ongoing medical condition? (diabetes, asthma or other chronic diseases, hypo-hyper thyroidism)	YES	NO	?
Have you had any surgery or operations, even minor one? (tonsillectomy, appendectomy)	YES	NO	?
Are you currently taking any prescription or non-prescription (over-the-counter) medicines or pills?	YES	NO	?
Are you allergic to any medications, stinging insects, foods, plants or pollen?	YES	NO	?
Have you ever had a rash or hives developed during or after exercise?	YES	NO	?
Vaccination Have you had a tetanus booster within the last 10 years? When?_____	YES	NO	?
Have you received your measles booster shot? Have you got vaccination against polio, rubella, hepatitis A yes 0 no 0	YES	NO	?
Have you received the hepatitis immunization series (all three shots)?	YES	NO	?
Do you have a missing organ? (kidney, an eye, a testicle (males), or any other organ?)	YES	NO	?
Have you had infectious mononucleosis (mono) within the last 6 months?	YES	NO	?
Do you have any rashes, pressure sores, or other skin problems?	YES	NO	?
Do you get frequent muscle cramps when exercising?	YES	NO	?
Do you have difficulties with falling asleep?	YES	NO	?
Do you feel tired?	YES	NO	?
Do you have good appetite?	YES	NO	?
Is your performance improving by plan?	YES	NO	?
Do you smoke cigarettes, use smokeless tobacco, or use tobacco in any form? Since when? How many packs a days	YES	NO	?
Do you use alcohol, and if yes, how often?	YES	NO	?
Have you used marijuana, cocaine, or any “street” recreational drugs?	YES	NO	?

FAMILY HISTORY:

Do you have any family members or relatives that have died before age 50?	YES	NO	?
Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? (Please underline if yes)	YES	NO	?
Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?	YES	NO	?
Is there anyone in your family who has diabetes mellitus?	YES	NO	?
Is there anyone in your family who has had cerebral insult before the age of 40 ys?	YES	NO	?
Do you have a familial blood disease? (thallasemia, sickle cell anemia etc.)	YES	NO	?
Is there anyone in your family who regularly uses alcohol, cocaine, marijuana, or other drugs or has undergone treatment for alcohol-or drug-related problems?	YES	NO	?

HEAD, NECK AND SPINE:

Have you ever had a head injury?	YES	NO	?
Have you ever had a concussion or been knocked unconscious?	YES	NO	?
Have you ever had a hit or blow to the head that caused confusion prolonged headache, or memory problems? (Football, rugby, soccer)	YES	NO	?
Have you ever had seizures or convulsions?	YES	NO	?

Do you have headaches with exercise/weight lifting?	YES	NO	?
Have you ever had numbness or tingling in your arms or legs after hitting another player?	YES	NO	?

SENSE ORGANS:

Do you have any problems with your eyes or vision?	YES	NO	?
Do you wear glasses, contact lens, or protective eyewear when you play?	YES	NO	?
Have you had any eye injuries?	YES	NO	?
Do you have any problems with your ears or hearing?	YES	NO	?
Have you had any ear injuries?	YES	NO	?

HEART:

Have you ever felt dizzy or passed out DURING exercise?	YES	NO	?
Have you ever felt dizzy or passed out During or AFTER exercise?	YES	NO	?
Have you ever had discomfort, pain, tightness or pressure in your chest during or after exercise?	YES	NO	?
Do you tire more quickly than your friends during exercise?	YES	NO	?
Do you get lightheaded or feel more short of breath than expected during exercise?	YES	NO	?
Have you ever had the feeling of your heart racing or skipped beats during or after exercise?	YES	NO	?
Have you ever been told you had high blood pressure or high cholesterol in your blood?	YES	NO	?
Have you ever had an electrocardiogram (EKG) of your heart? Normal 0 or abnormal 0 ?	YES	NO	?
Have you ever been told you have a heart murmur?	YES	NO	?
When exercising in the heat, do you have severe muscle cramps or become ill?	YES	NO	?
Have you ever had an unexplained seizure?	YES	NO	?

PULMONARY SYSTEM:

Have you ever been told you have asthma?	YES	NO	?
Do you cough, wheeze, or have trouble breathing **during or after exercise**?	YES	NO	?
Have you ever had tightness in your chest during exercise?	YES	NO	?
Have you ever used an inhaler or taken asthma medicine?	YES	NO	?

GASTROINTESTINAL SYSTEM:

Have you ever seen blood on you feces?	YES	NO	?
Have you ever noticed your feces to be black?	YES	NO	?
Have you ever hade constipation or diarrhea?	YES	NO	?

URINARY SYSTEM:

Do you have any difficulties with urination?	YES	NO	?
Have you ever noticed your urine to be bloody or dark?	YES	NO	?

LOCOMOTOR SYSTEM:

Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game?	YES	NO	?
Have you ever sprained/strained, dislocated, fractured/broken or other injuries to other bones/joints?	YES	NO	?
Do you regularly use a brace, orthotics or other assistive device?	YES	NO	?
Do you have a bone, muscle, or joint injury that bothers you?	YES	NO	?
Do any of your joints become painful, swollen, feel warm, or look red?	YES	NO	?
Do you have any history of juvenile arthritis or connective tissue disease?	YES	NO	?
Have you ever had a shoulder pain or injury?	YES	NO	?
Have you ever had a shoulder separation or shoulder subluxation/dislocation?	YES	NO	?
Have you ever had upper back pain or lower back pain?	YES	NO	?
Do you have any hernias, pelvic or groin pain?	YES	NO	?
Have you ever had pain or swelling in or around your knee?	YES	NO	?
Have you had any ankle sprains, swelling or weakness?	YES	NO	?
Do you have painful feet (callous/bunions) or flat feet?	YES	NO	?

Do you wear a brace or tape for participation?	YES	NO	?
Have you ever had a shin splint or stress fracture?	YES	NO	?
Have you ever been told you have low bone density (osteopenia or osteoporosis)?	YES	NO	?
Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below.	YES	NO	?

NUTRITION:

Have you had a weight change (loss or gain) of over 5 kg this year?	YES	NO	?
Are you on a special diet, i.e., vegetarian? Do you have food intolerance? Gluten, Lactulose??	YES	NO	?
Do you lose weight regularly to participate in your sport?	YES	NO	?
Do you want to weigh more or less than you presently do? Do you worry about your weight?	YES	NO	?
Have you restricted your food intake due to concerns about your weight or body size?	YES	NO	?
Have you had a history of anorexia, bulimia (forced vomiting), or any other eating disorder?	YES	NO	?
Have you used binge eating, vomiting, diet pills, sitting in a sauna, laxative use, diuretics (water pills), or similar techniques as a means of weight control?	YES	NO	?
Do you take any food supplements or vitamins?	YES	NO	?

FEMALES ONLY:

Have you ever had a menstrual period? Age of onset_____	YES	NO	?
Do you have painful or heavy periods?	YES	NO	?
Do you take any medications during your periods?	YES	NO	?
Do you take birth control pills or any female hormone (estrogen, progesterone)	YES	NO	?
Have you ever had any problems with your breasts?	YES	NO	?
Have you had a pelvic examination within the last year?	YES	NO	?
What was you most recent menstrual period? ….....			

How many periods have you had in the last 12 months? _____

PLEASE EXPLAIN »YES« ANSWERS HERE:

_____

_____

_____

_____

_____

_____

_____