Medical screening questionnaire

Patient information

Name: ……

Date of birth:……

Address:……

Telephone number……

Doctors name and surgery……

If you are not registered with a doctor – please state this on the form

Emergency contact information

Name:

Relationship:

Telephone number

Sports specific information

Sport and position

Others sports played:

Personal health history: If yes please explain further in the box provided

	Condition	
1.	Illness requiring medical attention in the past year?	☐ YES ☐ NO
2	Any recent surgery in the last 2 years?	☐ YES ☐ NO
3.	Are you under observation by a doctor for a problem?	☐ YES ☐ NO
4.	ECG's in the past?/History of abnormal ECG?	☐ YES ☐ NO
5.	Heart murmur or irregular or extra heart beats?	☐ YES ☐ NO
6.	Have you had any chest pains, dizziness, shortness of breath, excessive fatigue during exercise?	☐ YES ☐ NO
7.	Have you ever fainted or lost consciousness during exercise?	☐ YES ☐ NO
8.	Diabetes?	☐ YES ☐ NO
9.	High or low blood pressure?	☐ YES ☐ NO
10.	Asthma/exercise induced asthma?	☐ YES ☐ NO
11,.	Loss or problem with any paired organs (e.g. eye, testicles, kidneys	☐ YES ☐ NO
12.	Has anyone in your family suffered from high blood pressure, sudden death, heart attack or any hereditary disease?	☐ YES ☐ NO

Head Injury

	Condition	

1.	Have you ever had a concussion	☐ YES ☐ NO
2.	If yes how many?	
3.	When was you last concussion?	
4.	Ever you ever lost consciousness?	☐ YES ☐ NO
5.	If yes for how long?	
6.	Have you ever been kept out of sport with a concussion?	☐ YES ☐ NO

Please explain further if answered yes to any of these questions

Sports/non sports injuries

Please detail any injuries that you have had in the last 2 years. Please include dates and whether you had any treatment

Allergic reactions

1.	Do you have any allergies? (e.g stings, bites, food)	☐ YES ☐ NO
2	If yes what are you allergic to and what reaction do you develop?	
3	Do you carry an epi-pen?	☐ YES ☐ NO

I have read and fully understand this entire form. I have answered the questions thoroughly and accurately. I understand that it is my responsibility to inform the medical team of any changes to the medical form

Signed:…… Date:……

Signature of parent/guardian(Under18)……Date:……

Signed (therapist)……Date:……