

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

Head Injury

	Condition	

1.	Have you ever had a concussion	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.	If yes how many?	
3.	When was you last concussion?	
4.	Ever you ever lost consciousness?	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.	If yes for how long?	
6.	Have you ever been kept out of sport with a concussion?	<input type="checkbox"/> YES <input type="checkbox"/> 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)	<input type="checkbox"/> YES <input type="checkbox"/> NO
2	If yes what are you allergic to and what reaction do you develop?	
3	Do you carry an epi-pen?	<input type="checkbox"/> YES <input type="checkbox"/> 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:.....