**Sports medicine PPE questionnaire**

(Version: 01.02.2023)

Name, first name:       Date of birth:

Street:       Occupation:

Postal code/Place:       Phone:

Email:       Mobile:

Sport and discipline:

Level of competition:       Association/Club:

Swiss Olympic Card Cat./ Number:      /

Family doctor (with address/phone number.):

Federation/Club doctor\* (with address/phone):

Physical therapist\* (with address/phone):

**Informed Consent:**

I agree that the findings and diagnoses collected during my sports medicine pre-participation examination shall be stored and treated in accordance to confidentiality and personal medical data protection principles. I agree that the data collected can be accessed by my federation doctor, as well as by my family doctor.

With regard to scientific questions for the benefit of the further development of Swiss sport, I agree that my information can be used in anonymized form.

Athletes under 18 years of age require the written consent of their legal representative.

Place and date:

Signature of athlete and/or legal representative:

**1. Family**

a. Are your parents and siblings in good health?  yes  no

lf no, what conditions are they suffering from?

b. Does anyone in your family (close relatives} suffer (or has suffered) from any of the diseases listed below?

Heart disease  Diabetes  Rheumatic disease

Hypertension Cancer  Blood disease

Lung disease  Psychological disease other disease

Bronchial asthmaOsteoporosis

lf yes, please explain:

c. Do you have siblings and do they also play a sport (which one-s)?

Siblings (year of birth, gender, sport)

**2. Cardiovascular risk assessment**

1. When was your last medical check-up (physical examination with blood pressure measurement)?

1. Have you had an electrocardiogram (EKG) done in the last 2 years?

yes  no

1. Have your parents/doctors ever mentioned you had a heart problem and recommended you exercise or participate in sports only under medical supervision?

yes  no

1. Have you had chest pain or collapsed (loss of consciousness) in the past 2 years?

yes  no

1. Do you have any of the following at rest or during exertion? cough, shortness of breath, tightness or feeling of pressure in the chest or abdomen?

yes  no

1. Has a doctor declared you unfit for competition in recent years or are you aware of another reason why you should not participate in competitive sports?

yes  no

1. Has a doctor ever prescribed medicine for high blood pressure or for a heart condition?

yes  no

1. Do you smoke, have elevated cholesterol, suffer from high blood pressure or diabetes?

yes  no

1. Did someone in your family die suddenly before the age of 50 and/or do members (younger than 65 years old) of your family suffer from coronary heart disease, angina pectoris or had to undergo heart surgery?

yes  no

Explanations for questions 2a.-2i. if any of the questions were answered "yes":

**3. About yourself**

1. Do you currently suffer (or have you previously suffered) from **any health condition**, or undergone surgery:

yes no what when

heart/circulation

lungs

bronchial asthma

stomach/intestine

liver (jaundice)

kidneys/bladder/prostate

skin

eyes

teeth

throat

ears

frontal/maxillary sinuses

concussion

nervous system

epilepsy

diabetes

allergies, e.g. hay fever

adverse effect to medication

other

Which conditions are still current?

How are these conditions at the present time?

unchanged  improved  cured

Did you have to consult a medical doctor about it?

yes  no

If yes, name and address of the medical doctor:

1. Do you currently have or have you had any **musculoskeletal** injuries/complaints/surgeries?

yes no left right what when

neck

shoulder

arm

elbow

forearm

wrist

hand

back

pelvis

hip

thigh

knee

lower leg

achilles tendon

ankle joint

foot

other

Which conditions are still current?

How is this injury at the present time?

unchanged  improved  cured

Have you had to consult a medical doctor about this?  yes  no

If yes, name and address of the medical doctor:

1. Do you take medication on a regular basis?  yes  no

If so, which ones?

1. Do you have an TUE (Therapeutic Use Exemption) for special medication/drugs?  yes  no

If yes, please specify which medication/drug?

1. When was your last dental examination (which year)?
2. Have you received any vaccines in the last 5 years?

If yes, which ones and when?  yes  no

1. **Wellbeing/sleep**
2. How many hours do you sleep per night?       Hours
3. Do you have trouble falling asleep or staying asleep?  yes  no
4. Well-being: The following statements are about your well-being over the past two weeks. For each statement, please circle and note the number that you think best describes how you have been feeling over the past two weeks.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| *In the last*  *2 weeks….* | **All the time** | **Most of the time** | **More than half of the time** | **Less than half of the time** | **Some of the time** | **At no time** | **Points** |
| … I have felt cheerful and in good spirits. | 5 | 4 | 3 | 2 | 1 | 0 |  |
| … I have felt calm and relaxed. | 5 | 4 | 3 | 2 | 1 | 0 |  |
| … I have felt active and vigorous. | 5 | 4 | 3 | 2 | 1 | 0 |  |
| …I woke up fresh and rested. | 5 | 4 | 3 | 2 | 1 | 0 |  |
| … my daily life has been filled with things that interest me. | 5 | 4 | 3 | 2 | 1 | 0 |  |
|  |  |  |  |  |  | **Total**: |  |

1. **Weight, nutrition, supplements, alcohol, nicotine, drugs**
2. Has your weight been stable over the past two years?  yes  no
3. Have you intentionally lost or gained weight in the last two years?

yes  no

If yes, why?

c. Are you following a specific diet (e.g. lactose-free, gluten-free, FODMAP, etc.)?  yes  no

If yes, which one and why? Bring your dietary plan if applicable.

d. Do you have specific dietary preferences (e.g. no meat, vegetarian, vegan, etc.)?  yes  no

If yes, what specific dietary preference and since when?

e. Do you take any nutritional supplements (carbohydrates, proteins, etc.)?  yes  no

If so, what, how much, when?

f. Do you take other supplements (vitamins, magnesium, creatine, carnitine, etc.)?  yes  no

If so, what, how much, when?

g. Do you drink alcohol regularly?  yes  no

If so, what and how much?

           /day

h. Do you smoke or use other nicotine-containing substances such as snus (tobacco under the upper lip)?

yes  no

If yes, for how many years?       Years

If so, what and how much?

           /day

i. Do you currently use (or have you ever used) addictive drugs (e.g. THC, cocaine) or performance-enhancing drugs (e.g. anabolic steroids)?

yes  no

If so, what and how much?

1. **Sports/Training**
2. What does your current training plan look like?

Example of an average training week:

- Number of hours

- day(s) of rest, if any

In addition, you can add details about the specific abilities trained for each training session:

- Sport-specific or other training (e.g., strength, mental, recovery).

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Monday** | | **Tuesday** | | **Wednesday** | | **Thursday** | | **Friday** | | **Saturday** | | **Sunday** | | **Total** |
|  | [h] | Ability trained | [h] | Ability trained | [h] | Ability trained | [h] | Ability trained | [h] | Ability trained | [h] | Ability trained | [h] | Ability trained | [h] |
| **Morning** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Midday** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Afternoon** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Evening** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **Total** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

1. Do you keep a training diary?  yes  no
2. How do you monitor your training intensity (heart rate, lactate, perception of effort, etc.)?

1. Is your training periodized?  yes  no

If yes, how?

1. How has your performance curve been over the last 2 years?

increasing  constant  decreasing  alternating

1. **Recovery, sports psychology**
2. How often do you implement recovery measures?

massage        sauna

baths        other

1. Do you stretch on a regular basis?  yes  no
2. Do you regularly use a foam roller, e.g. Black Roll?  yes  no
3. Do you apply any sports psychology training methods?

yes  no

If yes, which ones?

1. **Self-assessment**
2. This question is about your overall satisfaction with life. How satisfied are you, all things considered, with your life at the present time?

not at all satisfied fully satisfied

0  1  2  3  4  5  6  7  8  9  10

1. Do you currently feel at your full capacity and able to perform?  yes  no

If no, why not?

1. **Questions?**

I would like to discuss the following questions: