Sports medicine PPE questionnaire

(Version: 01.02.2023)

Name, first name:

Street:

Postal code/Place:

Email:

Date of birth:

Occupation:

Phone:

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

If 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 asthma	☐ Osteoporosis	

If 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

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

b. Have you had an electrocardiogram (EKG) done in the last 2 years?
☐ yes ☐ no

c. 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

d. Have you had chest pain or collapsed (loss of consciousness) in the past 2 years?
☐ yes ☐ no

e. 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

f. 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

g. Has a doctor ever prescribed medicine for high blood pressure or for a heart condition?
☐ yes ☐ no

h. Do you smoke, have elevated cholesterol, suffer from high blood pressure or diabetes?
☐ yes ☐ no

i. 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

a. 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:

b. 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:

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

If so, which ones?

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

If yes, please specify which medication/drug?

e. When was your last dental examination (which year)?

f. Have you received any vaccines in the last 5 years?

If yes, which ones and when? ☐ yes ☐ no

4. Wellbeing/sleep

a. How many hours do you sleep per night? Hours

b. Do you have trouble falling asleep or staying asleep? ☐ yes ☐ no

c. 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:	

5. Weight, nutrition, supplements, alcohol, nicotine, drugs

a. Has your weight been stable over the past two years? ☐ yes ☐ no

b. 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?

6. Sports/Training

a. 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															

b. Do you keep a training diary? ☐ yes ☐ no

c. How do you monitor your training intensity (heart rate, lactate, perception of effort, etc.)?

d. Is your training periodized? ☐ yes ☐ no

If yes, how?

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

☐ increasing ☐ constant ☐ decreasing ☐ alternating

7. Recovery, sports psychology

a. How often do you implement recovery measures?

☐ massage ☐ sauna
☐ baths ☐ other

b. Do you stretch on a regular basis? ☐ yes ☐ no

c. Do you regularly use a foam roller, e.g. Black Roll? ☐ yes ☐ no

d. Do you apply any sports psychology training methods? ☐ yes ☐ no

If yes, which ones?

8. Self-assessment

a. 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

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

If no, why not?

9. Questions?

I would like to discuss the following questions: