Sports medicine health examination questionnaire for adults

Please answer the questions before the doctor's appointment. The properly completed questionnaire will greatly help your doctor in this health examination and providing evaluations and advice. The information in the questionnaire is confidential. Please explain your "yes" responses. You can add explanations at the end of questions or the questionnaire. Thank you!

Name: _____ ***Sex:*** *M* ☐ *F* ☐ ***Age:*** _____

Personal ID code: _____ ***Address:*** _____

Telephone: _____ ***E-mail:*** _____

1. Why are you having this health examination: health information ☐ to determine exercise tolerance ☐ recommendations for doing sports ☐ other ☐?

   _____

2. When and where have you had your last SEM or other health examination?

   _____

Questions about training

3. Training goals: to spend free time ☐ to keep fit ☐ to achieve better results ☐ other ☐_____

   _____

4. Specify the sport/sports _____ total duration _____
5. How many training sessions per week? _____Total: _____hours per week.
6. Is your straining load steady ☐ decreasing ☐ increasing ☐?_____
7. Have you had relatively long breaks in training? One month ☐ up to one year ☐ over one year ☐

   _____

8. Did you do sports at school? No ☐ Yes ☐ Which sport/sports? _____

   _____

9. Do you participate in competitions? No ☐ Yes ☐ How many times per year? in which sport/sports?_____
10. Competing objective? Joy of participation ☐ achieving results ☐

Questions about the lifestyle

11. Do you study ☐ work ☐? _____
12. Is your work physical ☐ sedentary ☐ intellectually challenging ☐?_____
13. Are you content with you sleep schedule and eating habits? Yes ☐ No ☐ _____
14. Are you following a special diet or do you avoid certain foods? No ☐ Yes ☐ _____

    _____

15. Have you made efforts to lose or gain weight or do you want to do so? No ☐ Yes ☐

    _____

16. Do you smoke? No ☐ Yes ☐

Questions about health

17. Do you have any troubles you would like to consult the doctor about? No ☐ Yes ☐_____

    _____

18. Last time you were ill with fever (month, year)? _____

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19. Do you have a chronic condition: heart disease ☐ diabetes ☐ asthma ☐ anaemia ☐ arterial hypertension ☐ kidney disease ☐ gastrointestinal disease ☐ eye disorder ☐ depression ☐ other ☐ _____
20. Do you take medicines or food supplements? No ☐ Yes ☐ Please list: _____ _____
21. Last time you saw a GP or medical specialist (month, year)? _____
22. Have you stayed in hospital in the past two years? No ☐ Yes ☐ _____
23. Have you had surgeries? No ☐ Yes ☐ _____
24. Do you have an allergy or/and food intolerance? No ☐ Yes ☐ _____
25. Do you wear glasses for vision correction? No ☐ Yes ☐ Contact lenses? No ☐ Yes ☐
26. Have you felt discomfort, tightness or pain in your chest during physical activity, after exercising or at rest? No ☐ Yes ☐ _____
27. Have you experienced dizziness, breathing difficulty, rapid heartbeat or irregular heartbeat during physical activity, after exercising or at rest? No ☐ Yes ☐ _____
28. Have problems with bones, joints or muscles prevented you from doing sports in the past year? No ☐ Yes ☐ _____
29. Among your close relatives (parents, siblings), have there been cases of sudden death ☐ or are you aware that any of them have(had): heart disease ☐ arterial hypertension ☐ a stroke ☐ diabetes ☐ excess weight ☐ asthma ☐ osteoporosis ☐ a tumour ☐ other condition ☐ _____

Questions for women only

30. Is your menstrual cycle regular? Yes ☐ No ☐ _____
31. Have you given birth? No ☐ Yes ☐ _____
32. Are you taking birth control pills? No ☐ Yes ☐ _____

You can add your explanations here

_____

_____

_____

By signing this questionnaire I confirm that I agree with the terms and conditions of Sports Medicine Foundation Privacy Policy (available in Estonian at www.sportmed.ee) and with the health care service provided to me.

I am willing to receive information regarding my health examination in an :

☐ *Pdf document via e-mail*

☐ *encrypted document via e-mail*

☐ *I am looking at the Terviseportaal*

Date: ____ /____ /_____ ***Name and signature of the patient*** _____

Veerenni 51, Tallinn 10138; telefon: +372 699 6515; e-post: admin@sportmed.ee
www.sportmed.ee