Sports Medical Health Questionnaire for Young Athletes ESMF-1

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

ID Code: _____ **Address:**_____

Phone:_____ **Email:** _____

School: _____

Sport(s) _____ **Coach(es):** _____

Sports school/club: _____

Training load: _____ times per week, total _____ academic hours. Competitions per month _____ times.
When and where the previous sports medical health examination took place:_____

Medications: please list all prescription, over-the-counter medications, and supplements you are currently taking.

Please tick the appropriate box ("yes" or "no") and explain any "yes" answers on the explanation line. Please circle the numbers of any questions you are unable to answer.

General questions	**Yes**	**No**
1. When was your most recent illness with fever?		
2. Do you have any concerns you would like to discuss with the doctor?	☐	☐
3. Has a doctor ever restricted or prohibited you from participating in sports for any reason?	☐	☐
4. Do you have any chronic illnesses (e.g. diabetes, asthma, anemia, hepatitis, etc.)?	☐	☐
5. Were you born without one kidney, eye, testicle (men), or any other organ, or has any organ been removed?	☐	☐
6. Have you ever been hospitalized?	☐	☐
7. Have you ever had surgery?	☐	☐
Explanation:		

Heart Health Questions About You	**Yes**	**No**
8. Have you ever fainted or nearly fainted during or after exercise?	☐	☐
9. Have you ever experienced discomfort, pain, or pressure in your chest **during exercise**?	☐	☐
10. Have you experienced any heart rhythm problems **during exercise** (e.g., palpitations, skipped beats, etc.)?	☐	☐
11. Has a doctor ever told you that you have heart problems? If yes, please specify: ☐ high blood pressure ☐ heart murmur ☐ high cholesterol ☐ myocarditis ☐ congenital heart disease ☐ other: _____	☐	☐
12. Has a doctor ever referred you for heart examinations (e.g., ECG, echocardiography)?	☐	☐
13. Do you get significantly more out of breath or tire faster than your training partners?	☐	☐
Explanation:		

Heart Health Questions About Your Family	**Yes**	**No**
14. Has any of your family members or relatives experienced a heart attack, stroke, heart-related death, sudden cardiac death, or required resuscitation due to cardiac arrest before the age of 50?	☐	☐
15. Does anyone in your family have congenital heart problems, a pacemaker, or an implanted defibrillator?	☐	☐
16. Has anyone in your family experienced unexplained fainting, seizures, or drowning?	☐	☐
Explanation:		

Musculoskeletal Questions	**Yes**	**No**

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17. Have you experienced any bone, muscle, ligament, or tendon injuries in the past year that caused you to miss training or competitions?	☐	☐
18. Have you ever had bone fractures (or cracks), stress fractures, or joint dislocations?	☐	☐
19. Have you had X-rays, MRI or CT scans, injections, or surgeries due to an injury, or have you used a cast, brace, or crutches?	☐	☐
20. Do you regularly use a brace or any other support device?	☐	☐
21. Do you have any bone, muscle, or joint injury that currently bothers you?	☐	☐
22. Do any of your joints hurt, feel warm, swell, or appear red?	☐	☐
23. Has a doctor ever told you that you have joint inflammation or a connective tissue disease?	☐	☐
Explanation:		

General Health Questions	**Yes**	**No**
24. Do you experience coughing, sneezing, breathing difficulties or shortness of breath **during exercise**?	☐	☐
25. Have you ever used an inhaler or asthma medication?	☐	☐
26. Does anyone in your family have asthma?	☐	☐
27. Do you have any allergies to medications, pollen, food, insects, etc.?	☐	☐
28. Do you experience groin pain, a painful mass, or a hernia in the groin area?	☐	☐
29. Have you had infectious mononucleosis in the past year?	☐	☐
30. Do you have any skin conditions?	☐	☐
31. Have you sustained any head injuries (head trauma) that caused loss of consciousness or memory loss?	☐	☐
32. Have you experienced seizures or seizure-related conditions?	☐	☐
33. Have you experienced headaches **during exercise**?	☐	☐
34. After a blow or fall, have you experienced numbness or weakness in your arms or legs lasting **more than 24 hours**, or an inability to move your arms or legs?	☐	☐
35. Have you ever felt unwell while exercising in hot weather?	☐	☐
36. Do you frequently experience muscle cramps **during exercise**?	☐	☐
37. Do you or any of your family members have anemia or any other blood disorder?	☐	☐
38. Have you experienced any vision problems or eye injuries?	☐	☐
39. Do you wear glasses or contact lenses during exercise?	☐	☐
40. Are you satisfied with your body weight?	☐	☐
41. Are you trying, or has anyone recommended, to lose or gain weight?	☐	☐
42. Are you on a special diet or do you avoid certain foods?	☐	☐
43. Have you ever had an eating disorder?	☐	☐
Explanation:		

FOR WOMEN ONLY	**Yes**	**No**
- Do you have menstrual periods?	☐	☐
- Do your periods occur monthly?	☐	☐
- At what age did you have your first menstrual period?		

If the doctor cannot give the health summary today, would you like to receive it later?

☐ As a PDF by email _____

☐ Encrypted by email. Parent's personal ID _____ and email _____

☐ I will check via the health portal.

By signing, I confirm that I have answered all questions honestly, consent to healthcare for me/my child, and agree to the processing of my/my child's sensitive personal data as described in the privacy policy at www.sportmed.ee

Date: ____ /____ / _____ *Athlete's signature* _____

Parent/guardian name and signature _____