high performance tri

MEDICAL SCREENING QUESTIONNAIRE

Personal Information Confidential Date

ATHLETE DETAILS

Name: M / F (please circle)

Address: Postcode:

Phone: (h) (w) (m)

Email:

D.O.B: Age:

Triathlon Australia License Number:

Club Member: Yes/No

If yes, which Club:

Please provide an emergency contact

Emergency contact name: Phone:

Relationship to athlete: Mobile:

GP and/or Medical Clinic:

Your Medicare Card No.

No. you are on the card: (e.g 1, 2, 3, 4)

MEDICAL QUESIONNAIRE (COMPULSORY)

Have you any new or ongoing illness/injury? Yes/No

If yes, please fill out details below

Diagnosis: _____

Treatment: _____

_____

_____

Has it interfered with your training? Yes/No

If yes, how long were you not training?	
How long were you in modified training?	
Are you currently in full training?	
If No, provide details of your current training restrictions	

Have you had any investigations i.e bloodtests, x-ray, MRI etc. Yes/No

If yes please provide details and results of the investigation (or attach the results)

_____

_____

Please list treating practitioners information (& provide any reports):

Name:

Occupation: (e.g Physio, Physician etc)

Contact No.

Email Address:

Name:

Occupation: (e.g Physio, Physician etc)

Contact No.

Email Address:

Yes No

❑ ❑ Do you have a heart condition? (Heart attack, murmur, heart surgery, irregular heart beat, palpitations etc)

❑ ❑ Do you ever experience unexplained pains in your chest at rest or during physical activity/exercise?

❑ ❑ Have you ever suffered a stroke?

❑ ❑ Do you ever feel faint, have spells of dizziness or experience chest pain during or after physical activity/exercise?

❑ ❑ Do you have Asthma?

❑ ❑ Do you have diabetes (type I or type II)?

❑ ❑ Do you have any diagnosed muscle, bone or joint problem that you have been told could be made worse by participating in physical activity/exercise?

❑ ❑ Do you have any other medical condition(s) that may make it dangerous for you to participate in physical activity/exercise?

IF YOU ANSWERED **YES** to any of the above questions, please seek medical guidance from your GP or appropriate allied health professional prior to undertaking physical activity/exercise (& provide clearance letter to HPT)

❑ ❑ Do you have high blood pressure or high cholesterol?

❑ ❑ Has anyone in the family died suddenly and unexpectedly before the age of 50?

❑ ❑ Do you have asthma, chest tightness, wheezing, or coughing spells during or after exercise?

If yes, provide details:_____

❑ ❑ Do you have any allergies?

If yes, provide details:_____

❑ ❑ Do you have a history of concussion or loss of consciousness?

If yes, provide details:_____

❑ ❑ Have you ever suffered a heat-related illness? (e.g. dizziness, cramps, blurred vision, disorientation, collapse, dehydration)

If yes, provide details:_____

❑ ❑ Do you have a chronic illness or see a physician regularly for any particular problem?

(e.g. diabetes, epilepsy, thyroid problems, bowel disorder)

If yes, provide details:_____

❑ ❑ Have you suffered from any injuries over the past 12 months that have affected your performance?

If yes, provide details:_____

❑ ❑ Have you spent time in hospital (including day admission) for any medical condition/illness/injury during the last 12 months?

If yes, provide details:_____

_____

❑ ❑ Do you take any prescribed medicine? (Include all asthma medications &/or nasal sprays for hayfever – even if only occasionally. This is important information for drug testing authorities)

If yes, please list type and dose:_____

❑ ❑ Do you take any prescribed or unprescribed medications?

If yes, please list type and dose:_____

_____

❑ ❑ Do you take or have any 'over the counter' supplements / medication / herbal remedies?

If yes, please list:_____

❑ ❑ Have you completed TUE's in the past or have any current TUE's operating?

If yes, please list:_____

❑ ❑ Do you wear contact lenses or glasses?

❑ ❑ Do you smoke? If yes, how many/day? _____

❑ ❑ Do you drink alcohol? If yes, average glasses/week? _____
Type (e.g. beer, spirits) _____

❑ ❑ Do you use any other forms of 'social drugs'?

❑ ❑ Do you suffer anxiety/stress/depression?

If yes, please detail (e.g clinically diagnosed, medication, treatment etc:_____

❑ ❑ Have you, or a close relative, ever suffered from depression?

❑ ❑ Have you ever suffered from excessive fatigue or overtraining?

❑ ❑ Do you wear orthotics?

If Yes to the above, please provide further details if not sufficient space to do so, or attach relevant medical reports.

Nutrition:

Yes No

❑ ❑ Do you follow any special diet? (e.g. vegetarian, weight loss, Pritikin)

❑ ❑ Have you ever suffered from an eating disorder?

❑ ❑ Have you ever had a nutritional deficiency diagnosed (e.g. iron, Vit. B12, calcium)

❑ ❑ Do you have milk/yoghurt/cheese on a daily basis?

❑ ❑ Do you eat red meat at least twice a week in your meals?

If Yes to the above, please provide further details if not sufficient space to do so, or attach relevant medical reports.

Female Athletes:

Yes No

❑ ❑ Have you started your periods? If yes, what age? _____

Date of your last gynecological exam/PAP smear _____ / _____ / _____

❑ ❑ Have you ever missed your period for more than 6 months?

Doctors Notes:

Please provide copies of any doctors notes on the above & any relevant additional information.

ATHLETES'S DECLARATION

I acknowledge that High Performance Tri ('HPT') is not able to provide me with medical advice and that the information I have provided is used as a screening for the purposes of coaching and exercise prescription.

I hereby certify:

- I believe that to the best of my knowledge, all of the information I have supplied is correct and true;
- I have read and understand the above information;
- I have answered all the questions to the best of my ability;
- I consider myself to be capable and in good health to participate in triathlon training;
- I understand that all athletes take part at their own risk and must accept personal liability for any injury or illness as a result of participating in triathlon training.

Participant's Signature: _____ Date: _____

Guardian's Signature (if participant under 18 years of age): _____

Date: _____