Centralny Ośrodek Medycyny Sportowej
COMS

Opiekun Polskiej Reprezentacji Olimpijskiej

# PREPARTICIPATION PHYSICAL EVALUATION

**Name**_____ **Date of Exam**_____ **Phone**_____

| **personal identity number** | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|

**Date of birth**_____

**Address**_____ **e-mail**_____ **Sport(s)**_____

**Circle the correct answer,** *for example .: 16. Have you ever spent the night in a hospital? ? If yes circle: (Yes) No*

| | | | |
|---|---|---|---|
| **1** | Do you currently feel / are you healthy? | Yes | No |
| **2** | Have you been sick for any disease since last month? | Yes | No |
| **3** | Has a doctor ever denied or restricted your participation in sports for any reason? | Yes | No |
| **4** | Do you have an ongoing medical condition (like diabetes or asthma)? | Yes | No |
| **5** | Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? | Yes | No |
| **6** | Have you ever passed out or nearly passed out? | Yes | No |
| **7** | Have you ever had discomfort, pain or pressure in your chest? | Yes | No |
| **8** | Has a doctor ever told you that you have (check all that apply): | Yes | No |

| | |
|---|---|
| High blood pressure | A heart murmur |
| High cholesterol | A heart infection |

| | | | |
|---|---|---|---|
| **9** | Has a doctor ever ordered a test for your heart? (for example: ECG, echocardiogram) | Yes | No |
| **10** | Does anyone in your family have a heart problem, is chronically ill or constantly taking medications? | Yes | No |
| **11** | Has any family member or relative died of heart problems or of sudden death before age 50? | Yes | No |
| **12** | Have you ever had an injury like a sprain, muscle or ligament tear or tendinitis, any broken or fractured bones or dislocated joints? If yes circle, below: | Yes | No |

| | | | | |
|---|---|---|---|---|
| Lower back | Neck | Elbow | Hip | Calf/Shin |
| Upper Back | Upper Arm | Forearm | Thigh | Ankle |
| Chest | Shoulder | Hand/Fingers | Knee | Foot/Toes |

| | | | |
|---|---|---|---|
| **13** | Have you ever had situations that required rehabilitation, physical therapy, bracing plaster or use stabilizers, braces, orthoses or sphere? | Yes | No |
| **14** | Have you had a bone or joint injury that required x-rays MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? | Yes | No |
| **15** | Have you been or are you actually under the care of a medical specialist? | Yes | No |
| **16** | Have you ever spent the night in a hospital? | Yes | No |
| **17** | Have you ever had surgery? | Yes | No |
| **18** | Do you have allergies to medicines, pollens, foods or or stinging insects? | Yes | No |
| **19** | Has a doctor ever told you that you have allergies? | Yes | No |
| **20** | Do you cough, wheeze, or have difficulty breathing during or after exercise? | Yes | No |
| **21** | Have you ever used an inhaler or taken asthma medicine? | Yes | No |
| **22** | Do you have (or had) chronic otitis, hearing disability, ears injury? | Yes | No |
| **23** | Do you have chronic rhinitis, nasal obstruction? | Yes | No |
| **24** | Do you have chronic inflammation of the pharynx, larynx and other problems which concern these organs? | Yes | No |
| **25** | Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? | Yes | No |
| **26** | Have you ever had seizures or has a doctor ever told you that you have epilepsy? | Yes | No |
| **27** | Do you have sometimes headaches and / or dizziness? | Yes | No |
| **28** | Have you ever had a head injury or concussion? | Yes | No |
| **29** | Have you ever been sick with meningitis (when)? | Yes | No |
| **30** | Has a doctor ever told you that you have anemia or iron deficiency? | Yes | No |
| **31** | Have you ever been to a psychiatrist? | Yes | No |
| **32** | Have you had any problems with your eyes or vision? | Yes | No |
| **33** | Do you wear glasses or contact lenses? | Yes | No |
| **34** | Have you put on weight or lose weight meaningful since last year? | Yes | No |
| **35** | Have you been vaccinate against infectious jaundice (hepatitis)? | Yes | No |
| **36** | Do you have any concerns that you would like to discuss with a doctor? | Yes | No |

**FEMALES ONLY**

| | | | |
|---|---|---|---|
| **37** | How old were you when you had your first mentrual period? | Yes | No |
| **38** | Do you menstruate regularly? | Yes | No |

**Explain „Yes" answers below in questions 2 - 32 as in example:** *ans. 16-appendix in 2004 or 14 years ago.*

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.
**I agree to conduct tests that are necessary to correct health assessment.**
I agree to use research findings anonymously for statistical and scientific purposes

_____ _____

*Signature player over 16 years old* *The signature of a parent or legal guardian of a minor*

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**PATIENT STATEMENT**

*Based on art. 9 and 23 of act from 6 november 2008 about patient rights and Patient Ombudsman (Dz. U. 31 march 2009) and act from 29 August 1997 about protection of personal rights (Dz. U. 1997 Nr 133 poz. 993) with later changes.*

I, the undersigned ……..……...….
*(Name)*

PESEL …….…….. I agree to giving me the health benefits or conducting tests.
……
*(date i sign)*

- I authorize Mr/Mrs ……..……..……
*(Name, adress)*

to access my medical documentation in case of my death / do not authorize anyone to access my medical documentation in case of my death **( delete as appropriate)*

- I declare that the person authorized to receive information about my my health, receiving health benefits and results of conducted tests is

Mr/Mrs …….
*(Name, adress)*

I declare that I was informed of the right to access to my data and to correct them.

Gdynia, on ……

……
*(patient's sign)*

……
*(sign of person receiving statement)*