General Information

Section 1: Personal Information

General	
First name:	
Surname:	
Date of birth:	Age:
ID number:	
Province:	Position:
Club:	
Address:	
Contact details	
Home:	Work:
Fax:	Cell:
Email:	
Next of kin	
First name:	
Surname:	
Relationship:	
Address:	
Contact details	
Home:	Work:
Fax:	Cell:
Email:	
Passport	
Nationality:	Number:
Players insurance	
Insurance fund:	
Number:	
Medical aid details	
Medical plan:	
Medical aid number:	
Medical team details	
Doctors name:	
Address:	
Contact numbers	
Work:	Cell:
Email:	
Physiotherapists name:	
Address:	
Contact numbers	
Work:	Cell:
Email:	

Consent:

I agree to undertake this procedure in order to enable medical personnel to ensure I am fit and trained to compete.
I am aware that some of this information may require clarification or follow up with my medical team, and agree to release relevant information.

I am aware that my fitness and health may be discussed with my coach.
I understand that information contained in this questionnaire is otherwise confidential and can only be released with my consent.

Name:
Parent/guardian signature if athlete is under 18 years of age.

Signature: _____ **Date:** _____

Athlete Medical Information

(To be completed by the athlete prior to Screening)

Section 2: General Medical History

Current medical symptoms:

Please list any current health concerns:

1: _____
2: _____
3: _____
4: _____
5: _____

Please indicate if you have suffered from any of the following in the last 3 months:

Visual disturbances	Yes ☐	Hearing difficulties	Yes ☐
Hoarseness	Yes ☐	Chronic sinusitis	Yes ☐
Chest pain/Angina	Yes ☐	Wheezing	Yes ☐
Palpitations	Yes ☐	Shortness of breath	Yes ☐
Swollen ankles	Yes ☐	Chronic cough (>3months)	Yes ☐
Frequent fainting/blackouts	Yes ☐	Calf pain with exercise	Yes ☐
Abdominal cramps	Yes ☐	Change in bowel habits	Yes ☐
> 5kg weight gain/loss	Yes ☐	Loss of appetite	Yes ☐
Frequent thirst or urination	Yes ☐	Rectal bleeding	Yes ☐
Heartburn	Yes ☐	Nausea/vomiting	Yes ☐
Regular headaches	Yes ☐	Muscle weakness	Yes ☐
Pins and needles	Yes ☐	Depression/anxiety	Yes ☐
Concussion	Yes ☐		
Difficulty in urination	Yes ☐	Pain on urination	Yes ☐
Bleeding on urination	Yes ☐	Poor urinary stream	Yes ☐

Have you noticed any new spots on the skin Yes ☐

Have any existing spots or new spots changed colour, size or shape Yes ☐

Medical history:

Have you ever suffered from or been diagnosed as having?

Concussion	Yes ☐	Stroke	Yes ☐
High blood pressure	Yes ☐	Heart murmur	Yes ☐
High Cholesterol	Yes ☐	Asthma	Yes ☐
Diabetes	Yes ☐	Hepatitis	Yes ☐
Angina	Yes ☐	Epilepsy	Yes ☐
Heart attack	Yes ☐	Arthritis	Yes ☐
Gout	Yes ☐	Marfans syndrome	Yes ☐
Irregular heart beat	Yes ☐	Congenital heart disease	Yes ☐
Heat/exercise related collapse	Yes ☐		

No to all above ☐

Has a physician ever restricted your participation in sport owing to heart problems? Yes ☐

Drs Notes:

Allergies:

Do you have any allergies to medication, foods, insects or other agents? No ☐

If Yes:

	Allergen/s	
Food		
Medicine		
Other		

Medications/supplements:

Have you within the last three months taken any prescription medication? No ☐

If Yes:

Medication	Currently use: Y/N	Dose	Route	Frequency	Duration of use

Do you use any over the counter supplements/ medication/ herbal remedies? No ☐

If Yes:

Name	Brand	Currently use :Y/N	Dose	Frequency	Duration of use

Has the IRB been ***notified*** of medication usage? Yes ☐ No ☐ Unsure ☐

Protective/ergogenic equipment:

Do you wear contact lenses or glasses? Yes ☐ No ☐ Unsure ☐

Do you wear Orthotics? Yes ☐ No ☐ Unsure ☐

Do you wear Protective equipment? No ☐

If Yes:

Protective equipment	Training	Competition
Headgear		
Gum guard		
Shinpads		
Shoulder pads		

Surgical history:

Have you ever had surgery or required hospitalization? No ☐

If Yes:

Condition	Date(mm/yy)	Surgeon/Doctor	Operation

Family medical history:

Do you have a family history of any of the conditions below?

Condition	Family member	Age of diagnosis
Sudden death <50 years		
Heart Disease		
High Blood pressure		
High Cholesterol		
Cancer		
Arthritis		
Diabetes		
Stroke		
Marfans syndrome		
Eye disease		

Habits:

Do you smoke? No ☐ Ex smoker ☐

If yes

Number per day ☐☐ Number of years as a smoker ☐☐

Do you take recreational drugs? No ☐

If yes

Type: ..... Frequency: ..... Last event: .....

Do you drink alcohol? No ☐

If yes

Type: .....

No. of units per week: ☐☐

Do you drink more than three drinks in a sitting? Yes ☐ No ☐ Unsure ☐

How many times per week do you drink more than three drinks? ☐☐

Nutrition:

Have you ever struggled to make the required weight for your sport? No ☐

If yes Overweight ☐ Underweight ☐

By how many kilograms are you under/overweight? ☐☐

Do you follow a special diet? No ☐

If yes

Vegan: ☐ Vegetarian: ☐ Other: .....

Have you ever had a nutritional deficiency diagnosed? No ☐

If Yes, what was deficient? : .....

Female athletes only:

Have you started your periods? Yes ☐ No ☐ Unsure ☐

If Yes Age of onset: .....

Date of Last menstrual period: .....

Date of last Normal Menstrual period: .....

Could you be pregnant? Yes ☐ No ☐ Unsure ☐

Date of last pap smear: .....

Have you ever missed your period for more than six months? Yes ☐ No ☐ Unsure ☐

Does your menstruation affect your performance? Yes ☐ No ☐ Unsure ☐

Vaccinations:

Have you ever had a vaccination for?

Vaccination				Age at vaccination:
Tetanus	Yes ☐	No ☐	Unsure ☐	
Measles, mumps and Rubella (MMR)	Yes ☐	No ☐	Unsure ☐	
Influenza	Yes ☐	No ☐	Unsure ☐	
Hepatitis A	Yes ☐	No ☐	Unsure ☐	
Hepatitis B	Yes ☐	No ☐	Unsure ☐	
Polio	Yes ☐	No ☐	Unsure ☐	
Other	Yes ☐	No ☐	Unsure ☐	

Injuries:

Please document all injuries that have caused you to miss training or matches for longer than one week in the last year. Please use the table below to document fully all injuries. Injuries are divided into:

- Current injuries: These are injuries that are currently keeping you out of training and competition.
- Past Acute injuries: This refers to injuries that were due to a sudden direct or indirect cause.
  Examples: You injured your hamstring when sprinting for the ball. You fractured your ribs when you were cleaned out at the ruck.
- Chronic Injuries: This refers to injuries that have had a gradual insidious onset. These are injuries that if not attended to get worse over time.

Please fill in the injury tables using the numbers specified for the choices given in the description table on Page 9 E.G.:
If you were tackled and you dislocated your right shoulder. Treatment was surgery and physiotherapy. You are still under the physio's care. Fill in as follows

Body Part	Side	Date	Management	Mechanism	Type of Injury	Status of Injury
Shoulder	R	mm/yy	5; 6	13	10	1; 2

Number	Management	Mechanism	Type of Injury	Status of injury
1	Medication	Acceleration	Contusion/bruise	Current
2	Sutures	Deceleration	Bone bruise	Acute
3	Advice	Lunging	Cartilage injury	Chronic
4	Strapping/bracing	Sidestep	Meniscal injury	
5	Surgery	Slipped	Ligament Sprain	
6	Physiotherapy	Twisted	Ligament rupture	
7	Biokinetics	Kicking	Muscle Strain	
8	Chiropractor	Running	Muscle rupture	
9	Other	Scrum engagement	Fracture	
10		Scrum collapse	Joint dislocation	
11		Popped scrum	Nerve injury	
12		Tackling	Vascular injury	
13		Tackled	Disc injury	
14		Collision	Hernia	
15		Bitten	Other	
16		Elbowed		
17		Gouged		
18		Head butt		
19		Kicked		
20		Kneed		
21		Punched		
22		Rucked		
23		Cleaned		
24		Cleaning		
25		Jumping		
26		Not Supported		
27		Landing		
28		Other		

Table of All Current and Old Injuries

Insert all the details of your injuries using the numbers and format designated above.

Body Part	Side	Date	Management	Mechanism	Type of Injury	Status of Injury

Do you have any other health or injury concerns that you want to discuss with the sports physician?

Yes ☐ No ☐ Unsure ☐