PRELIMINARY INFORMATION FORM FOR HEALTH CHECK

Terveystalo

Date:_____ Name: _____ Gender:_____

Personal identity code:_____ Sport: _____ Profession/student: _____

Address:_____

Personal medical specialist:_____

Coach:_____ Next of kin (+ telephone number) _____

Respond to the following questions with 'yes' or 'no'.
If your response is 'yes', please provide a specification to the Specification field below; also indicate the number of the question to which the specification refers.

		Yes	No
1.	Has your medical specialist prohibited you from participating in a training session/competition?	☐	☐
2.	Do you have any chronic illnesses (such as asthma, diabetes)?	☐	☐
3.	Do you use any over-the-counter or prescription medication on a regular basis?	☐	☐
4.	Have you had any food or drug allergies?	☐	☐
5.	Have you had any other allergies (to pollen, animals, etc.)?	☐	☐
6.	Have you experienced pressure or pain in your chest during an exercise or competition performance?	☐	☐
7.	Have you had heart arrhythmia (tachycardia, i.e. "fluttering" or "skipping a beat") during an exercise or competition performance?	☐	☐
8.	Has a medical specialist ever diagnosed you with any of the following:		
	a. high blood pressure	☐	☐
	b. abnormal heart sounds	☐	☐
	c. abnormal cardiogram results	☐	☐
	d. abnormal blood counts	☐	☐
9.	Do you have a history of known cardiovascular diseases in your family?	☐	☐
10.	Have there been any unexpected deaths related cardiovascular issues in your family?	☐	☐
11.	Have you had any surgery?	☐	☐
12.	Have you had any sudden muscle, tendon or ligament injuries?	☐	☐
13.	Have you had any stress-related muscle or tendon injuries?	☐	☐
14.	Have you had recurring back pain?	☐	☐
15.	Have you had bone fractures?	☐	☐
16.	Have you had any stress-related bone injuries (such as stress fractures)?	☐	☐
17.	Have you experienced shortness of breath during exercise?	☐	☐
18.	Do you have a history of asthma in your family?	☐	☐
19.	Have you ever needed to use asthma medication?	☐	☐
20.	Do you have a tendency to get rashes (e.g. atopic dermatitis, hidradenitis, etc.)?	☐	☐
21.	Over the past 12 months, have you had any recurring (more than 3 times) infections (flu, sore throat, head cold, bronchitis, ear infection, etc.)?	☐	☐
22.	Have you ever lost consciousness or suffered a concussion?	☐	☐
23.	Have you been diagnosed with epilepsy or attacks of swoons or cramps?	☐	☐
24.	Do you have a history of known neurologic diseases (MS, Parkinson's, epilepsy, stroke) in your family?	☐	☐
25.	Do you have frequent stomach aches or disorders (diarrhea, nausea, etc.)?	☐	☐
26.	Have you had any urinary diseases (such as urinary tract infections, haematuria, etc.)?	☐	☐
27.	Are you satisfied with your current weight?	☐	☐
28.	Have you experienced difficulties falling asleep or other sleep disorders?	☐	☐
29.	Do you feel a need for any of the following:		
	a. Losing weight?	☐	☐
	b. Gaining body mass?	☐	☐
	c. Are you on a special diet?	☐	☐
	d. Do you use any nutrition supplements?	☐	☐
(30.)	At what age did you get your period? _____		
(31.)	My menstrual cycle is regular and lasts approximately _____		
	My menstrual cycle is irregular; I menstruate approximately _____ times a year		
	I have not gotten my period yet ☐		
	I have not had a period for _____ months		
(32.)	Do you use any medicinal birth control (contraceptive pill, IUD, etc.)?	☐	☐
33.	Have you received the following vaccinations (if yes, when):		
	a. tetanus? _____		
	b. Hepatitis A or B? _____		
	c. others vaccines according to the Finnish vaccination programme? _____		
34.	Any further matters not addressed above?	☐	☐

PRELIMINARY INFORMATION FORM FOR HEALTH CHECK

Terveystalo

Specification (also indicate the question number):

NOTE: Children aged 16 or younger must provide a growth curve from the school nurse or child health clinic.
All patients should bring their vaccination record, if possible.