Centralny Ośrodek Medycyny Sportowej
COMS

PREPARTICIPATION PHYSICAL EVALUATION

Name_____ **Date of Exam**_____ **Phone**_____

personal identity number											

Date of birth_____

Address_____ **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)