

**TRIATHLON AUSTRALIA
ELITE SQUAD
MEDICAL SCREENING 2003**

CONTACT DETAILS

NAME

DOB.....

HOME ADDRESS.....

.....
.....
.....

CONTACT PHONE NO (HOME).....

(MOBILE).....

EMERGENCY CONTACT

NAME.....

CONTACT PHONE NO (HOME).....

(MOBILE).....

ADDRESS.....

.....
.....

GENERAL MEDICAL QUESTIONS

Circle appropriate answer

Have you ever suffered from a heat related illness?	Y	N
Have you ever suffered from dizziness or blackouts during exercise?	Y	N
Have you ever been diagnosed with a heart murmur?	Y	N
Have you ever had any chest pain or chest pain during exercise?	Y	N
Have you ever been diagnosed with asthma?	Y	N
If yes have you filled out an asthma notification form?	Y	N
If yes have you had laboratory testing?	Y	N
Do you get any wheeze, cough or shortness of breath during or after exercise?	Y	N
Do you suffer from hay fever?	Y	N
Do you wear orthotics?	Y	N
Do you wear glasses or contact lenses?	Y	N
Do you have any family history of heart disease or sudden cardiac death?	Y	N
Do you drink alcohol?	Y	N
Have you ever been diagnosed with iron deficiency?	Y	N

MEDICAL HISTORY

ALLERGIES

(Include any allergies to medications)

.....
.....
.....

VACCINATIONS

(Tick box if you have had vaccination and where possible fill in date it was given)

Tetanus	<input type="checkbox"/>	__/__/__	Hepatitis B	<input type="checkbox"/>	__/__/__
Polio	<input type="checkbox"/>	__/__/__	Whooping Cough	<input type="checkbox"/>	__/__/__
Mumps	<input type="checkbox"/>	__/__/__	Influenza	<input type="checkbox"/>	__/__/__
Measles	<input type="checkbox"/>	__/__/__	Meningococcal	<input type="checkbox"/>	__/__/__
Hepatitis A	<input type="checkbox"/>	__/__/__			

FAMILY HISTORY

(List any significant family medical history e.g parent with heart disease, diabetes, hypertension)

.....
.....
.....
.....

LONGSTANDING/CHRONIC MEDICAL PROBLEMS

(List any ongoing medical problems for which you have treated- e.g Asthma, Diabetes, epilepsy, hepatitis, heart problems)

.....
.....
.....
.....
.....

SURGERY/HOSPITAL ADMISSIONS

(List any surgery you have had or any hospital admissions and the date they occurred)

.....
.....
.....
.....
.....

PAST INJURIES

(List any previous significant injury that inhibited or prevented your training. Give an approximate date that the injury occurred and a brief summary of any treatment you had)

Injury.....
Treatment.....

.....
.....
.....

Injury.....
Treatment.....

.....
.....
.....

Injury.....
Treatment.....

.....
.....
.....

Injury.....
Treatment.....

.....
.....
.....

CURRENT HEALTH PROBLEMS

(List any current medical problems. E.g worsening asthma, iron deficiency, fatigue, recent illness)

.....
.....
.....
.....
.....

CURRENT/RECENT INJURY

(List any current injury problems. Include any recent investigations and what treatment you have been having)

.....
.....
.....
.....
.....
.....
.....
.....
.....
.....

MEDICATIONS

(List all medications that you are currently taking. Include inhaled asthma medications and the contraceptive pill)

Medication

Dose

.....
.....
.....
.....
.....
.....
.....

SUPPLEMENTS

(List any supplements you are taking. Include any supplements you may take before you race)

.....
.....
.....
.....
.....
.....
.....

WOMAN ONLY

Do you have periods?	Y	N
Does your menstruation affect your performance e.g pain, cramps, prolonged bleeding?	Y	N
Are your periods regular?	Y	N
Are you taking the contraceptive pill?	Y	N

TRIATHLON SPECIFIC QUESTIONS

What is your preferred race distance? sprint / short course / long course / ironman

What is your current training load?

Run	_____	km
Cycle	_____	km
Swim	_____	km
Ride/Runs	_____	km
Weights	_____	sessions

Have you changed your bike set-up recently?	Y	N
---	---	---

If so, when and what?.....

Do you wear orthotics?	Y	N
------------------------	---	---

Do you have any common areas of: tightness? (Where).....
weakness?(Where).....

**THIS INFORMATION WILL BE STRICTLY CONFIDENTIAL
AND WILL BE KEPT SECURE.**