

Malta Triathlon Association

PRE - COMPETITION MEDICAL CHECKUP

APPLICANTS NAME: _____

DATE OF BIRTH: ____/____/____

NAME OF PRIVATE DOCTOR: _____

DOCTOR'S PHONE: _____

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF, HAVE YOU EVER BEEN TREATED FOR OR EVEN HAD ANY KNOWN INDICATION OF:

Diabetes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Glaucoma, increased eye pressure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Heart Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Deficiency in colour vision	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
High Blood Pressure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Thyroid trouble	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Stroke	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Gall bladder trouble	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Kidney Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Jaundice	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Tuberculosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Kidney or bladder stone	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cancer	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Sugar or albumin in urine	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Liver Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Blood in urine	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Hepatitis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Swollen painful joints	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Stomach Trouble or Ulcer	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Severe pains in back or neck	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Anaemia or other blood disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Back Injury	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Mental illness	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Constant numbness of a body part	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Scarlet Fever	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Paralysis of a body part	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Rheumatic Fever	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Loss of any body part	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Malaria	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	"Trick" shouder, elbow or knee	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Syphilis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Locking of joint movement	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Coughing up blood	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Limitation of joint movement	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Chronic lung condition	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Bone Disease or deformity	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Asthma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Fit or convulsion	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Heart murmur	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Loss of memory (amnesia)	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Unconsciousness for any reason	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Vomiting of blood	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Severe head injury	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Alcoholism or drug abuse	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Blindness in either eye	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

HAVE YOU EVER BEEN:

Rejected from sports for medical reason?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Rejected from an insurance policy for medical reasons?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Advised to have a surgical procedure?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Treated by a physician within the past 3 years except for minor illnesses or injuries?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Hospitalised?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

DO YOU HAVE A FAMILY HISTORY OF:

Diabetes	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Tuberculosis	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Epilepsy	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Asthma	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Kidney Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Heart Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
High Blood Pressure	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Stroke	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Cancer	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Blood Disease	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No

DO YOU NOW HAVE OR ARE YOU CURRENTLY HAVING TROUBLE WITH ANY OF THE FOLLOWING:

<table border="0" style="width: 100%;"> <tr><td>Frequent Respiratory Infections</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Frequent Sinus Trouble</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Pleurisy</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Persistent Cough</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Frequent Shortness of Breath</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Any infectious disease</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Irregular or rapid heart</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Frequent chest pain</td><td><input type="checkbox"/> Yes</td><td><input type="checkbox"/> No</td></tr> <tr><td>Dizzy spells or fainting</td><td><input 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Please explain details of all yes answers (Attach additional sheet if necessary)

I hereby affirm to the best of my knowledge my answers to the foregoing questions and statements are true and complete
 I also declare that if throughout the forthcoming triathlon racing season I develop/learn of any particular medical condition, I shall provide the Malta Triathlon Association with a letter describing my current medical condition.

Signature of Athlete _____

Date _____

Additional Comments

Signature obo Malta Triathlon Association _____

Date _____

