Officials Medical Screening

Beijing 2022 Olympic Winter Games

AIS

AUSTRALIAN OLYMPIC TEAM

SECTION 1

PROSPECTIVE TEAM MEMBER INFORMATION

For completion by Prospective Team official prior to attending a medical appointment

Name:_____ Date of birth: _____

Address: _____

_____

Home phone:_____ Mobile: _____

Email: _____

Sport: _____

SECTION 2

MEDICAL QUESTIONNAIRE

For completion by Prospective Team official prior to attending a medical appointment

Asthma

☐ No ☐ Yes (current) ☐ Yes (past)

Details: _____

Bronchitis / Lung disease

☐ No ☐ Yes (current) ☐ Yes (past)

Details: _____

High Blood Pressure

☐ No ☐ Yes (current) ☐ Yes (past)

Details: _____

Anaemia / other blood disorder

☐ No ☐ Yes (current) ☐ Yes (past)

Details: _____

Heart disease (including heart murmur)

☐ No ☐ Yes (current) ☐ Yes (past)

Details: _____

Ear, Nose, Throat disease

☐ No ☐ Yes (current) ☐ Yes (past)

Details: _____

Diabetes

☐ No ☐ Yes (current) ☐ Yes (past)

Details: _____

Digestive disease (including heartburn, ulcer)

☐ No Yes (current) Yes (past)

Details: _____

Bowel disease (including haemorrhoids)

☐ No Yes (current) Yes (past)

Details: _____

Liver disease (including hepatitis)

☐ No Yes (current) Yes (past)

Details: _____

Kidney disease (including bladder infection, stones)

☐ No Yes (current) Yes (past)

Details: _____

Cancer / cysts / tumour

☐ No Yes (current) Yes (past)

Details: _____

Arthritis / gout / any joint pains

☐ No Yes (current) Yes (past)

Details: _____

Hay fever

☐ No Yes (current) Yes (past)

Details: _____

Allergies (food, drugs, other)

☐ No ☐ Yes (current) ☐ Yes (past)

Details: _____

Headaches (including migraine)

☐ No ☐ Yes (current) ☐ Yes (past)

Details: _____

Epilepsy / convulsions / blackouts

☐ No ☐ Yes (current) ☐ Yes (past)

Details: _____

Depression / anxiety / thoughts of self-harm / other mental illness

☐ No ☐ Yes (current) ☐ Yes (past)

Details: _____

If 'Yes (current) are you accessing professional services to assist you with this? ☐ Yes ☐ No

If you are accessing professional services, is this from a: ☐ Doctor ☐ Psychologist ☐ Psychiatrist ☐ Other

Family History

Please outline any family history of chronic illness, and death / illness under the age of 50:

_____

_____

_____

Illness

Please list any current or previous illnesses which necessitated hospitalisation or ongoing treatment. Include dates:

_____

_____

_____

Injuries

Please list all current and past injuries which resulted in reduced activities or exercise participation. Include dates:

_____

_____

_____

Medication(s)

Please list all medications / vitamins / supplements you are currently taking:

Surgical Operations

Please list all previous surgical operations. Include dates:

SECTION 3

EXERCISE PARTICIPATION

For completion by Prospective Team official prior to attending a medical appointment

Do you participate in regular physical activity? _____

What activity(ies)? _____

How often per week? _____

Total minutes per week: _____

Doctor's Notes: _____

_____

_____

SECTION 4

DENTAL HEALTH

For completion by Prospective Team official prior to attending a medical appointment

It is important that all prospective Team members maintain good dental health. It is therefore highly recommended that you have a dental check up in the 12 months prior to the 2022 Olympic Games.

Date of last dental check-up: _____

Date of next dental check-up: _____

Dentist name: _____

Dentist Telephone: _____

Dentist Address: _____

Additional comments: _____

SECTION 5

IMMUNISATIONS

For completion by Prospective Team official prior to attending a medical appointment

Yes	No	Unsure	Important	
☐	☐	☐	☐	Have you had the Australian recommended childhood and high school age vaccinations (including MMR)?
☐	☐	☐	☐	Influenza (after March 1st 2021)
☐	☐	☐	☐	Hepatitis A
☐	☐	☐	☐	Hepatitis B
☐	☐	☐	☐	Gardasil
☐	☐	☐	☐	Whooping Cough (Pertussis) Booster (within last 5 years)
☐	☐	☐	☐	Tetanus Booster (within last 10 years)
☐	☐	☐	☐	Meningococcal
☐	☐	☐	☐	COVID-19 Vaccine (all doses)
☐	☐	☐	☐	Typhoid

Where indicated by circumstance:

Yes	No	Unsure	Important	
☐	☐	☐	☐	Yellow Fever
☐	☐	☐	☐	Dukoral

SECTION 6

PHYSICAL EXAMINATION

For completion by examining Medical Practitioner

Height (cm):_____ Weight (kg):_____ Body Mass Index: _____

Comments: _____

Cardiovascular

Blood pressure:_____ Heart rate:_____ Heart rhythm:_____

Added sounds:_____ Peripheral circulation: _____

Comments: _____

Ear / Nose / Throat

Respiratory:_____ Abdominal:_____ Neurological: _____

Skin (sun damage, suspicious lesions, rash):_____

Comments: _____

Visual Acuity without correction

Right:_____ Left: _____

Visual Acuity with correction

Right:_____ Left: _____

Additional notes as required:

_____

_____

_____

SECTION 7

INVESTIGATIONS AS INDICATED

For completion by examining Medical Practitioner

Blood tests:_____ ECG: _____

CXR:_____ Urinalysis: _____

Spirometry:_____ Other tests: _____

Significant findings:

Specialist referral (if indicated):

Additional notes as required:

Management recommendations:

SECTION 8

MEDICAL PRACTITIONER DETAILS

For completion by examining Medical Practitioner

Name of Medical Practitioner: _____

Signature: _____

Date: _____

Phone: _____ Fax: _____

Email: _____