Medical Screening for Athletes 2025

二零二五年運動醫療檢查

Particulars 個人資料

Full Name 姓名: (中文) _____ (English) _____ Sex 性別: _____

Date of Birth 出生日期(D/M/Y): ___/___/___ ID Card No.身份證號碼: _____

Sport Team 體育項目: _____

Home Address 住址: _____

Home Tel. No.住址電話號碼: _____ Contact No. 聯絡電話號碼: _____

Family Doctor 家庭醫生: _____ Dr. Contact No.醫生電話號碼: _____

Health Questionnaire 健康問卷 (To be filled by athlete 由運動員填寫)

Part 1. Past Injuries 以往病歷

Do you have, or have you ever had, any of the following conditions? If so, please state when:

你現在或過去是否有以下情況，請列明發生時間：

Yes 是	No 否		Year 年份	Recovered 已經痊癒	Not Yet 尚未痊癒
☐	☐	Head injury 頭部受傷			
☐	☐	Neck injuries 頸部受傷			
☐	☐	Shoulder injuries 肩部受傷			
☐	☐	Elbow injuries 肘部受傷			
☐	☐	Arm/ Wrist/ Hand injuries 前臂/手腕/手部			
☐	☐	Back injuries 腰背受傷			
☐	☐	Rib cage injuries 肋骨受傷			
☐	☐	Hip injuries 髖部受傷			
☐	☐	Thigh injuries 大腿受傷			
☐	☐	Knee injuries 膝部受傷			
☐	☐	Lower leg injuries 小腿受傷			
☐	☐	Ankle injuries 踝部受傷			
☐	☐	Foot injuries 足部受傷			
☐	☐	Other? 其他			

Have you been advised to restrict activity during the last five years? Please give details:
過去五年曾否被勸告禁止某類活動，如有的，請詳細列明：

Past Illness or Medical Problems 有關過去的病歷或內科問題

Do you have, or have you ever had, any of the following conditions? If so, please state when:
你現在或過去是否有以下情況，請列明發生時間：

Yes 是	No 否		Year 年份	Recovered 已經痊癒	Not Yet 尚未痊癒
☐	☐	Frequent headaches 經常頭痛			
☐	☐	Fainting spells or dizziness 失去知覺或頭暈			
☐	☐	Illness when exposed to high temperature 在高溫下不適			
☐	☐	Epilepsy or convulsions 癲癇症			
☐	☐	Numbness or tingling 麻痺			
☐	☐	Frequent Nosebleeds 經常流鼻血			
☐	☐	Difficulty in hearing or vision 聽覺或視覺有毛病			
☐	☐	Tuberculosis 肺結核			
☐	☐	Rheumatic Fever 風濕性熱			
☐	☐	Heart Disorder (e.g. abnormal heart beat, chest pain) 心臟有毛病 (如心跳異常、胸口痛)			
☐	☐	High blood pressure 高血壓			
☐	☐	Diabetes 糖尿病			
☐	☐	Anemia 貧血			
☐	☐	Thyroid disorders 甲狀腺問題			
☐	☐	Skin disorders 皮膚病			
☐	☐	Asthma 哮喘			
☐	☐	Loss of, or serious impairment of, a paired organ (e.g. kidney, eye) 器官失去或嚴重受傷 (如腎臟、眼)			
☐	☐	Hepatitis or jaundice 肝炎/黃膽病			
☐	☐	Infectious mononucleosis 感染性單核血球病			
☐	☐	Frequent bowel cramps or upsets 經常攪肚			
☐	☐	ulcer pain 胃痛			
☐	☐	Rectal bleeding 痔血			
☐	☐	Melena 黑糞症 (black stool) (大便發黑)			
☐	☐	Kidney and bladder problems 腎臟或膀肛毛病			
☐	☐	Any menstruation 有否月經？			
		If yes, what age? 如有開始年齡？ _____			
☐	☐	Menstrual problems 月經失調, if yes, please tick in appropriate box : 如答 "是"，請選擇：			
	☐	Amount : more than normal 量過多			
☐	☐	Amount : less than normal 量過少			
N/A	☐	Frequency : every 3 weeks or below per cycle 期數：每一次相隔三星期或以下			
	☐	Frequency : every 6 weeks or above per cycle 期數：每一次相隔六星期或以上			
	☐	Dysmenorrhea 經痛			

Yes 是 | No 否

☐ ☐ Any allergies (e.g. skin itching, difficulty in breathing, dizzy, etc.)
Food 食物 _____
Drugs/medicines 藥物 _____
During or after exercise 運動中或運動 _____
If yes，please specify any reactive changes 如有，請列明反應_____

☐ ☐ Do you follow any special diet (e.g. vegetarian) 有否特別飲食 (如素食)？

_____

☐ ☐ Do you smoke? 是否有吸煙的習慣？
How many cigarettes a day? 每天吸多少枝煙？

_____

☐ ☐ Have you been hospitalised or had operation(s) done on any occasion? Please give details:
如有住院或做手術記錄，請列出事件的原因及詳情：

_____

_____

_____

☐ ☐ Please list any prescriptions(s) that you are now using at regular basis : (including Chinese herbal medicine & vitamins) : 請列出你現時所服用的藥物：(包括中藥及維他命) ：

_____

Have you been immunized against 你是否曾經接受免疫注射 ：

☐ ☐ Hepatitis A 甲型肝炎? Yes 是/ No 否 If yes, indicate date 請寫出注射日期 ：

_____

☐ ☐ Hepatitis B 乙型肝炎? Yes 是/ No 否 If yes, indicate date 請寫出注射日期 ：

_____

☐ ☐ Tetanus 破傷風? Yes 是/ No 否 If yes, indicate date : 請寫出注射日期：

_____

Part 2. Family Medical History 家人健康背景

Is there a family history of the following problems? 家人是否有以下問題:

Yes 是 | No 否 | Unsure 不清楚

☐ ☐ ☐ Coronary heart disease 心臟病
☐ ☐ ☐ Diabetes 糖尿病
☐ ☐ ☐ Stroke, High blood pressure 中風，高血壓
☐ ☐ ☐ Marfan syndrome 馬凡氏綜合症
☐ ☐ ☐ Thalassemia 地中海貧血
☐ ☐ ☐ Has anyone in the family (grandparents, parents, brother, sister, aunt, uncle ... etc.) died suddenly before the age of 50 years? 家中是否有成員在 50 歲前突然死亡，包括祖父母、父母、兄弟姊妹、姨母、姑母、舅父、叔伯…等 ？

Name 姓名: _____

Sport 運動項目: _____ Sex 性別: _____ Age 年齡: _____

Part 3. PHYSICAL EXAMINATION

Height 身高: _____ (cm) Weight 體重: _____ (kg)

Blood Pressure 血壓: _____ / _____ Pulse 脈搏: _____

Vision OK: _____ Needs investigation: _____

Dental OK: _____ Needs investigation: _____

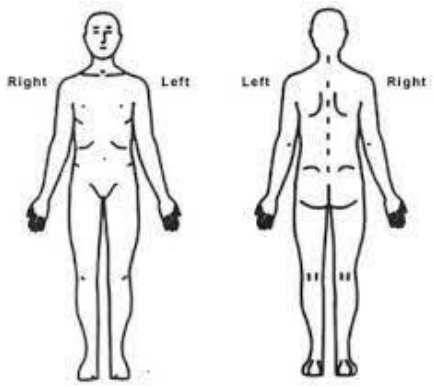
	Normal	Abnormal/Comment
Eyes/Fundus		
Ears, Nose, Throat		
Head and Neck		
Skin and Scalp		
Lymphatics		
Thorax		
Lungs		
Heart Sounds		

Murmur Yes _____ No _____

Brachia-femoral delay Yes _____ No _____

Abdomen		
Hernia		
Genitalia		
Neurologic		

Handiness : L / R Please indicate the location of the body part(s) of concern at the picture on the right:



Part 4. LABORATORY TEST RESULTS-

Please attach CBC and Urinary Analysis Result

Advice:_____

Part 5. 12-lead Resting ECG- Please attach

Summary Assessment of ECG Normal☐ Abnormal☐ please specify:

Physician's signature: _____ Date: _____

(Name in block letters with address chop)

(For doctor's use only)

Part 6. REVIEW BY DOCTOR

_____ No athletic participation

_____ Limited Participation, e.g. _____

_____ Clearance withheld until: _____

_____ Unlimited participation: _____

Advice:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Based on the results of Part 1 to Part 6, the reviewed athlete is fit for

Elite Athletic Training and Competition Yes☐ No☐

Doctor signature: _____ Date: _____

(Name in block letters with address chop)