|  |  |
| --- | --- |
| **C:\Users\help\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Outlook\2DGS6MNS\SNI SINI RGB Stacked (3).jpg** | Sport Northern Ireland Sports InstituteUlster UniversityShore RoadNewtownabbeyCo. AntrimBT37 0QB |

# Sport Northern Ireland Sports Institute – Medical Performance Profiling Questionnaire

The following will take a maximum of 20 minutes to complete. This questionnaire is to assist in identifying any medical issues that need addressed or any areas of health which can be optimized to improve your athletic performance. Any answers to these questions are strictly confidential.

All athletes should complete sections 1-. **Female** athletes only should complete Section 14. Only those athletes who have an **EXISTING DIAGNOSIS OF ASTHMA** should complete Section 15.

This questionnaire should be completed prior to your initial medical appointment at SNI Sports Institute. Thank you for your participation.

**Please do not print this form**

*Complete electronically and email your return to* *medicaladmin@sportni.net*

*Click check boxes to mark your answer and a* [x]  *will appear.*

## Section 1 - General Athlete Information

Date Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
|  Athlete Name: |  Sport: |  Date of Birth: |  Sex: |
|  |  |  |  [ ]  Female [ ]  Male |
|  Athlete e mail: |  Athlete phone number: |
|  |  |

## Section 2 - Support Services

|  |  |
| --- | --- |
| GP Name:  |  |
| GP Address: |  |
| Physiotherapist: |  |
| Strength & Conditioning Coach: |  |
| Sports Nutritionist: |  |
| Sports Psychologist: |  |
| Physiologist: |  |
| Podiatrist: |  |

## Section 3 – Sport and Training Details

|  |  |
| --- | --- |
| Position *(if applicable)*: |  |
| Weight Class *(if applicable)*: |  |

[ ] Right Hand Dominant [ ]  Left Hand Dominant [ ] Ambidextrous

### Please give an approximate outline of your weekly training schedule.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Day | Mon | Tue  | Wed | Thurs | Fri | Sat | Sun |
| Am |  |  |  |  |  |  |  |
| Pm |  |  |  |  |  |  |  |

### Please detail any major competitions and training camps over the next 12 months.

|  |
| --- |
|  |

### How do you monitor training load/fatigue? *(Tick all that apply)*

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Training diary – resting HR, muscle soreness etc. | [ ] Mobile phone App e.g. Restwise | [ ] Physiologist | [ ] GPS |
| [ ] Blood screening | [ ]  Salivary monitoring | [ ]  Coach/S&C monitored | [ ]  No regular monitoring |
| [ ]  Other –*Please specify* |

## Section 4 – Nutrition and Weight

### Are there any foods that are routinely avoided/ are you following a specific diet (e.g. vegetarian)?

[ ]  Yes | [ ]  No

*If Yes please give details -*

### Have you any food allergies?

### [ ]  Yes | [ ]  No

*If Yes please give details –*

### When was your last DEXA scan, if ever?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please list all nutritional supplements used e.g. protein shakes/bars, vitamins, fish oils etc.

### What is your normal weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Kg

### How often do you eat dairy products (e.g. milk, cheese, butter, yoghurt)?

[ ] Never [ ]  At least once per week

[ ] Daily [ ]  Less than once per week

### Do you worry about your weight?

### [ ]  Yes | [ ]  No

### How much would your weight fluctuate during the year?

High (Kg)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Low(Kg)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Are you trying to, or has anyone recommended that you gain or lose weight?

### [ ]  Yes | [ ]  No

### Have you ever had an eating disorder?

### [ ]  Yes | [ ]  No

### Have you ever had a stress fracture?

### [ ]  Yes | [ ]  No

### Have you ever been told that you have low bone mineral density (osteopenia/osteoporosis)?

### [ ]  Yes | [ ]  No

## Section 5 – Smoking & Alcohol

### Any history of smoking?

[ ]  Yes | [ ]  No

*If Yes please give details -*

### Do you currently take alcohol?

### [ ]  Yes | [ ]  No

*If Yes please give details –*

## Section 6 – Medication

### Are you allergic to any medication?

### [ ]  Yes | [ ]  No

*If Yes please give details –*

### Please list all current medications -

### Have you had any therapeutic use exemption certificates (TUEs) granted in the past 12 months?

### [ ]  Yes | [ ]  No

*If Yes please give details –*

## Section 7 – Immunisation History

|  |  |  |
| --- | --- | --- |
| **Immunisation** | **Please tick if Yes** | **Approximate date of last injection** |
| Tetanus  | [ ]  |  |
| Polio  | [ ]  |  |
| Typhoid | [ ]  |  |
| Rubella | [ ]  |  |
| Hepatitis A | [ ]  |  |
| Hepatitis B | [ ]  |  |
| Meningitis C | [ ]  |  |
| Yellow fever | [ ]  |  |
| Chicken pox | [ ]  |  |
| Influenza (Flu vaccine) | [ ]  |  |
| Other (please specify) |

## Section 8 – Current Medical History

### Please list any medical conditions that **currently** affect you -

### Please detail any medical conditions/hospital admissions/surgeries you have had in the past:

### Please list any previous injuries that have prevented you training for > 2 weeks. Please start with the most recent first –

|  |  |  |
| --- | --- | --- |
| **Date of Injury** | **Nature of Injury** | **Management and time-off from training/sport** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## Section 9 - Concussion History and Modifiers

### How many concussions do you think you have had in the past?

### When was the most recent concussion?

### How long was your recovery from the most recent concussion?

### Have you ever been hospitalized or had medical imaging done for a head injury?

### [ ]  Yes | [ ]  No

### Have you ever been diagnosed with headaches or migraines?

### [ ]  Yes | [ ]  No

### Do you have a learning disability, dyslexia, ADD / ADHD?

### [ ]  Yes | [ ]  No

### Have you ever been diagnosed with depression, anxiety or other psychiatric disorder?

### [ ]  Yes | [ ]  No

### Has anyone in your family ever been diagnosed with any of these problems?

### [ ]  Yes | [ ]  No

## Section 10 – Family History

Have any of the following conditions occurred in a male relative aged less than 55 years or a female relative less than 65 years? *(Please check boxes)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition** | **No** | **Father** | **Mother** | **Sibling** | **Other** |
| Sudden cardiac death | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Sudden infant death | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Coronary heart disease | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Cardiomyopathy | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Hypertension | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Recurrent faints/collapse | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Arrhythmias | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Heart transplantation | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Heart surgery | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Pacemaker/Defibrillator | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Marfan Syndrome | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Unexplained drowning | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Unexplained car accident | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Stroke | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Diabetes | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Cancer | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| Other (arthritis etc.) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

## Section 11 – Systems Review

Please check boxes as appropriate – If ‘Yes’ to any question please give details at the end of the table.

|  |  |  |  |
| --- | --- | --- | --- |
|  **Systems Questions** | **Yes** | **No** | **Unsure** |
| **Cardiovascular System** |
| Have you ever suffered from chest pain/dizziness/passing out during/after exercise? | [ ]  | [ ]  | [ ]  |
| Have you ever suffered from a heart abnormality/murmur diagnosed by a doctor? | [ ]  | [ ]  | [ ]  |
| Any abnormal heart rate/palpitations/irregular heart beat? | [ ]  | [ ]  | [ ]  |
| Have you ever had high blood pressure/cholesterol? | [ ]  | [ ]  | [ ]  |
| Any restrictions in sport due to heart problems? | [ ]  | [ ]  | [ ]  |
| **Respiratory System** |
| Have you ever suffered from asthma/chest tightness/ coughing spells during/ after exercise? | [ ]  | [ ]  | [ ]  |
| Have you ever suffered from recurrent chest infections/ bronchitis? | [ ]  | [ ]  | [ ]  |
| **Neurological System** |
| Have you ever suffered from concussion/fits/faints? | [ ]  | [ ]  | [ ]  |
| Do you suffer from headaches or migraines? | [ ]  | [ ]  | [ ]  |
| Any history of loss of consciousness/head injury requiring time off from training or playing? | [ ]  | [ ]  | [ ]  |
| **Gastrointestinal & Genitourinary System** |
| Any constipation or diarrhoea? | [ ]  | [ ]  | [ ]  |
| Any abdominal pain/bloating? | [ ]  | [ ]  | [ ]  |
| Any blood/altered blood in the motions? | [ ]  | [ ]  | [ ]  |
|  **Systems Questions** | **Yes** | **No** | **Unsure** |
| Any heartburn? | [ ]  | [ ]  | [ ]  |
| Any nausea or vomiting? | [ ]  | [ ]  | [ ]  |
| Do you ever have urine infections? | [ ]  | [ ]  | [ ]  |
| Any difficulty or pain when passing urine? | [ ]  | [ ]  | [ ]  |
| **Males only** – Any lumps on the testes/scrotum? | [ ]  | [ ]  | [ ]  |
| **General Health** |
| Any history of recurrent infections? | [ ]  | [ ]  | [ ]  |
| Any loss of appetite/weight loss? | [ ]  | [ ]  | [ ]  |
| Any recurrent ear/nose/throat/sinus infections? | [ ]  | [ ]  | [ ]  |
| Any skin problems – eczema, psoriasis, cold sores etc? | [ ]  | [ ]  | [ ]  |
| Any muscle aches? | [ ]  | [ ]  | [ ]  |
| Do you wear glasses? | [ ]  | [ ]  | [ ]  |
| Do you wear contact lenses? | [ ]  | [ ]  | [ ]  |
| If you wear glasses/contact lenses do you see an optician regularly? | [ ]  | [ ]  | [ ]  |
| Do you use a gum shield for your sport? | [ ]  | [ ]  | [ ]  |
| Have you had a dental check-up in the past 6 months? | [ ]  | [ ]  | [ ]  |
| Do you use insoles/orthotics in any of your footwear? | [ ]  | [ ]  | [ ]  |

### Please supply further details below (if applicable):

## Section 12 - AQUA© Questionnaire *– Scores for positive answers for each question are in brackets*

### 1) Did any doctor diagnose you with an allergic disease? (4)

[ ]  Yes | [ ] No

If yes, which ones?

[ ]  Asthma [ ]  Rhinitis [ ]  Conjunctivitis

[ ]  Urticaria [ ]  Eczema [ ]  Drugs allergy

[ ]  Food allergy [ ]  Insect venom allergy (bees, wasps) [ ]  Anaphylaxis

### 2) Do you suspect to suffer from allergy, independently from any medical diagnosis? (4)

[ ]  Yes | [ ]  No

### 3) Did you ever use anti-allergic drugs (antihistamines, topical steroids, ‘‘allergy vaccines’’)? (3)

[ ]  Yes | [ ]  No

### 4) Is there anyone with allergies in your family?

[ ]  No [ ]  Yes, mother and father (3)

[ ]  Yes, mother or father (2) [ ]  Yes, other relatives (1)

### 5) Have you frequently red eyes with tearing and itching? (2)

[ ]  Yes | [ ]  No

### 6) Do you frequently sneeze, have a running, itchy nose (apart from colds)? (5)

[ ]  Yes | [ ]  No

### 7) Did you ever feel tightness of your chest and/or wheeze? (2)

[ ]  Yes | [ ]  No

### 8) Have you ever had itchy skin eruptions? (2)

[ ]  Yes | [ ]  No

### 9) Have you ever had severe allergic or anaphylactic reactions? (2)

[ ]  Yes | [ ]  No

### 10) Have you ever had shortness of breath, cough and/or itching of the throat following exercise? (2)

[ ]  Yes | [ ]  No

If yes, you have more difficulties:

[ ]  At the beginning of the training session [ ]  At the end of the training session [ ]  During the whole training session

### 11) If you suffered from any of the above, did these symptoms occur: (Not Scored)

[ ]  Mainly outdoor [ ]  Mainly indoor [ ]  Mainly in spring

[ ]  Mainly in cold or humid conditions [ ]  Independently of any environmental condition

### 12) Have you ever had allergic reactions to foods? (3)

[ ]  Yes | [ ]  No

If yes, do you remember to which food?

### 13) Do you frequently suffer from upper respiratory infections (pharyngitis, bronchitis, colds) or fever? (Not Scored)

[ ]  Yes | [ ]  No

If yes, are these infections are more frequent during overtraining periods?

[ ]  Yes | [ ]  No

### 14) Do you suffer for recurrent labial herpes (cold sores)? (Not Scored)

[ ]  Never [ ]  1–3 times/year [ ] More than 3 times/year

### 15) How many times in the last year you could not train because of infections? (Not Scored)

[ ]  Never [ ]  1–3 times [ ]  More than 3 times

## Section 13 - Sleep Quality Assessment (PSQI)

### What is PSQI, and what is it measuring?

The Pittsburgh Sleep Quality Index (PSQI) is an effective instrument used to measure the quality and patterns of sleep in adults. It differentiates “poor” from “good” sleep quality by measuring seven areas (components): subjective sleep quality, sleep latency, sleep duration, habitual sleep efficiency, sleep disturbances, use of sleeping medications, and daytime dysfunction over the last month.

### INSTRUCTIONS:

The following questions relate to your usual sleep habits during the past month only. Your answers should indicate the most accurate reply for the majority of days and nights in the past month. Please answer all questions.

**During the past month –**

### 1. When have you usually gone to bed?

### 2. How long (in minutes) has it taken you to fall asleep each night?

### 3. What time have you usually gotten up in the morning?

### 4A. How many hours of actual sleep did you get at night?

### 4B. How many hours were you in bed?

|  |  |
| --- | --- |
|  | **Please check appropriate boxes** |
| **5. During the past month, how often have you had trouble sleeping because you**… | Not during the past month (0)  | Less than once a week (1)  | Once or twice a week (2)  | Three or more times a week (3)  |
| A. Cannot get to sleep within 30 minutes  | [ ]  | [ ]  | [ ]  | [ ]  |
| B. Wake up in the middle of the night or early morning  | [ ]  | [ ]  | [ ]  | [ ]  |
| C. Have to get up to use the bathroom  | [ ]  | [ ]  | [ ]  | [ ]  |
| D. Cannot breathe comfortably  | [ ]  | [ ]  | [ ]  | [ ]  |
| E. Cough or snore loudly  | [ ]  | [ ]  | [ ]  | [ ]  |
| F. Feel too cold  | [ ]  | [ ]  | [ ]  | [ ]  |
| G. Feel too hot  | [ ]  | [ ]  | [ ]  | [ ]  |
| H. Have bad dreams  | [ ]  | [ ]  | [ ]  | [ ]  |
| I. Have pain  | [ ]  | [ ]  | [ ]  | [ ]  |
| J. Other reason (s), please describe, including how often you have had trouble sleeping because of this reason (s):  | [ ]  | [ ]  | [ ]  | [ ]  |
| 6. During the past month, how often have you taken medicine (prescribed or “over the counter”) to help you sleep?  | [ ]  | [ ]  | [ ]  | [ ]  |
| 7. During the past month, how often have you had trouble staying awake while driving, eating meals, or engaging in social activity?  | [ ]  | [ ]  | [ ]  | [ ]  |
| 8. During the past month, how much of a problem has it been for you to keep up enthusiasm to get things done?  | Very good (0) | Fairly good (1) | Fairly bad (2) | Very bad (3) |

## Section 13 – Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times.

Even if you haven’t done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the **most appropriate number** for each situation:

0 = would **never** doze

1 = **slight chance** of dozing

2 = **moderate chance** of dozing

3 = **high chance** of dozing

|  |  |
| --- | --- |
|  | **Please check appropriate boxes** |
| Please tick the appropriate column.**Situation -**  | 0 = would **never** doze | 1 = **slight chance** of dozing | 2 = **moderate chance** of dozing  | 3 = **high chance** of dozing |
| Sitting and reading | [ ]  | [ ]  | [ ]  | [ ]  |
| Watching TV | [ ]  | [ ]  | [ ]  | [ ]  |
| Sitting, inactive in a public place (e.g. a theatre or a meeting) | [ ]  | [ ]  | [ ]  | [ ]  |
| As a passenger in a car for an hour without a break | [ ]  | [ ]  | [ ]  | [ ]  |
| Lying down to rest in the afternoon when circumstances permit | [ ]  | [ ]  | [ ]  | [ ]  |
| Sitting and talking to someone | [ ]  | [ ]  | [ ]  | [ ]  |
| Sitting quietly after a lunch without alcohol | [ ]  | [ ]  | [ ]  | [ ]  |
| In a car, while stopped for a few minutes in the traffic | [ ]  | [ ]  | [ ]  | [ ]  |

## Section 14 - The LEAF-Q - A Questionnaire for Female Athletes

***PLEASE COMPLETE PAGES 14-16 (Section 14) ONLY IF YOU ARE A FEMALE ATHLETE – If not please go to page 17 (Section 15)***

# 1. Injuries - Please mark the response that most accurately describes your situation

### **A:** Have you had absences from your training, or participation in competitions during the last year due to injuries?

[ ]  No, not at all [ ]  Yes, once or twice

[ ]  Yes, three or four times [ ]  Yes, five times or more

### **A1:** If yes, for how many days absence from training or participation in competition due to injuries have you had in the last year?

[ ]  1-7 days [ ]  8-14 days

[ ]  15-21 days [ ]  22 days or more

### **A2:** If yes, what kind of injuries have you had in the last year?

# 2. Gastrointestinal function

### **A**: Do you feel gaseous or bloated in the abdomen, even when you do not have your period?

[ ]  Rarely or never [ ]  Yes, several times a day

[ ]  Yes, several times a week [ ]  Yes, once or twice a week or more seldom

### **B**: Do you get cramps or stomach ache, which cannot be related to your menstruation?

[ ]  Rarely or never [ ]  Yes, several times a day

[ ]  Yes, several times a week [ ]  Yes, once or twice a week or more seldom

### **C**: How often do you have bowel movements on average?

[ ]  Several times a day [ ]  Once a day [ ]  Every second day

[ ]  Twice a week [ ]  Once a week or more rarely

### **D**: How would you describe your normal stool?

[ ]  Normal (soft) [ ]  Diarrhoea-like (watery) [ ]  Hard and dry

# 3. Menstrual function and use of contraceptives

### 3.1 Contraceptives - Mark the response that most accurately describes your situation

A: Do you use oral contraceptives?

[ ]  Yes | [ ]  No

A1: If yes, why do you use oral contraceptives?

[ ]  Contraception [ ]  Reduction of menstruation pains [ ]  Reduction of bleeding

[ ]  To regulate the menstrual cycle in relation to performances etc.

[ ]  Otherwise menstruation stops [ ]  Other

**A2:** If no, have you used oral contraceptives previously?

[ ]  Yes | [ ]  No

**A2:1** If yes, when and for how long?

### **B:** Do you use any other kind of hormonal contraceptives? (e.g. hormonal implant or coil)

[ ]  Yes | [ ]  No

**B1:** If yes, what kind?

[ ]  Hormonal patches [ ]  Hormonal ring [ ]  Hormonal coil

[ ]  Hormonal implant [ ]  Other

### **3.2 Menstrual function Mark the response that most accurately describes your situation**

### **A**: How old were when you had your first period?

[ ]  11 years or younger [ ]  12-14 years [ ]  15 years or older

[ ]  I don’t remember [ ]  I have never menstruated \*

***\*If you have answered “I have never menstruated” there are no further questions to answer – proceed to page 17.***

### **B:** Did your first menstruation come naturally (by itself)?

[ ]  Yes [ ]  No [ ]  I don’t remember

### **C:** Do you have normal menstruation?

[ ]  Yes [ ]  No **(go to question C6)** [ ]  I don’t remember **(go to question C6)**

**C1:** If yes, when was your last period?

[ ]  0-4 weeks ago [ ]  1-2 months ago

[ ]  3-4 months ago [ ]  5 months ago or more

**C2:** If yes, are your periods regular? (Every 28th to 34th day)

[ ]  Yes, most of the time [ ]  No, mostly not

### **C3:** If yes, for how many days do you normally bleed?

[ ]  1-2 days [ ]  3-4 days [ ]  5-6 days

[ ]  7-8 days [ ]  9 days or more

**C4:** If yes, have you ever had problems with heavy menstrual bleeding?

[ ]  Yes | [ ]  No

**C5:** If yes, how many periods have you had during the last year?

[ ]  12 or more [ ]  9-11 [ ]  6-8

[ ]  3-5 [ ]  0-2

**C6:** If no or “I don’t remember”, when did you have your last period?

[ ]  2-3 months ago [ ]  4-5 months ago

[ ]  6 months ago or more [ ]  I’m pregnant and therefore do not menstruate

### **D:** Have your periods ever stopped for 3 consecutive months or longer (besides pregnancy)?

[ ]  No, never [ ]  Yes, it has happened before [ ]  Yes, that’s the situation now

### **E:** Do you experience any changes with your menstruation when you increase your exercise intensity, frequency or duration?

[ ]  Yes | [ ]  No

**E1:** If yes, in what way(s)? (Check one or more options)

[ ]  I bleed less [ ]  I bleed fewer days [ ]  My menstruations stops

[ ]  I bleed more [ ]  I bleed more days

### **F:** To your knowledge, have you ever had anaemia?

[ ]  Yes [ ]  No [ ]  I don’t know

### **G:** Have you ever supplemented with iron?

[ ]  Yes [ ]  No [ ]  I don’t know

### **H:** Have you ever experienced any of the following? (*tick all that apply)*

[ ]  Flooding through to clothes or bedding

[ ]  Need of frequent changes of sanitary towels or tampons *(changes every 2 hours or less, or 12 sanitary items per period)*

[ ]  Pass large blood clots

[ ]  Need of double sanitary protection *(tampons and towels)*

## Section 15 - ASTHMA Control

***PLEASE COMPLETE SECTION 15 ONLY IF YOU HAVE BEEN PREVIOUSLY DIAGNOSED WITH ASTHMA – IF NOT PLEASE PROCEED TO PAGE 20***

### The ASTHMA CONTROL TEST is a quick test for people with asthma 12 years and older. It provides a numerical score to help assess asthma control.

### INSTRUCTIONS:

### Please check the boxes with your answer.

|  |  |
| --- | --- |
| 1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or home? | **Score:** |
| All of the time (1)[ ]  | Most of the time (2)[ ]  | Some of the time (3)[ ]  | A little of the time (4)[ ]  | None of the time (5)[ ]  |  |
| 2. During the past 4 weeks, how often have you had shortness of breath? |  |
| More than once a day (1)[ ]  | Once a day (2) [ ]  | 3-6 times per week (3)[ ]  | Once or twice a week (4)[ ]  | Not at all (5)  [ ]  |  |
| 3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning? |  |
| 4 or more nights/ week (1) [ ]  | 2 or 3 nights/ week (2) [ ]  | Once per week (3)  [ ]  | Once or twice (4)[ ]  | Not at all (5)[ ]  |  |
| 4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as salbutamol)? |  |
| 3 or more times/day (1)[ ]  | 1 or 2 times/day (2)[ ]  | 2 or 3 times/ week (3) [ ]  | Once a week or less (4)[ ]  | Not at all (5)[ ]  |  |
| 5. How would you rate your asthma control during the past 4 weeks? |  |
| Not controlled at all (1)[ ]  | Poorly controlled (2)[ ]  | Somewhat controlled (3)[ ]  | Well controlled (4)[ ]  | Completely controlled (5)[ ]  |  |
| **TOTAL:** |  |

### ASTHMA SUFFERERS ONLY - Mini – Asthma Quality of Life Questionnaire (MiniAQLQ)©:

Please check all questions that best describe how you have been during the last 2 weeks as a result of your asthma.

In general, how much of the time during the last 2 weeks did you:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | All of time (1) | Most of the time (2) | A good bit of the time (3) | A little of the time (4) | Some of the time (5) | Hardly any of the time (6) | None of the time (7) |
| 1. Feel short of breath as a result of your asthma (S) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 2. Feel bothered by, or have to avoid dust in the environment (En) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 3. Feel frustrated as a result of your asthma (Em) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 4. Feel bothered by coughing (S) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 5. Feel afraid of not having your asthma medication available (Em) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 6. Experience a feeling of chest tightness or chest heaviness (S) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 7. Feel bothered by or have to avoid cigarette smoke in the environment (En) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 8. Have difficulty getting a good nights sleep as a result of your asthma (S) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 9. Feel concerned about having asthma (Em) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 10. Experience a wheeze in your chest (S) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 11. Feel bothered by or have to avoid going outside because of weather or air pollution (En) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

How limited have you been during the last 2 weeks doing these activities as a result of your asthma?

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | All of time (1) | Most of the time (2) | A good bit of the time (3) | A little of the time (4) | Some of the time (5) | Hardly any of the time (6) | None of the time (7) |
| 12. Strenuous activities (Such as hurrying, exercising, running upstairs, sports) (A) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 13. Moderate activities (Such as walking, housework, gardening, shopping, climbing stairs) (A) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 14. Social activities (Such as talking, playing with pets/children, visiting friends/relatives) (A) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 15. Work-related activities (tasks that you have to do at work)\* (A) | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

***\*If you are not employed or self-employed, these should be tasks you have to do most days. (S): symptoms; (En): environment; (Em): emotions; (A): activities.***

## Section 16 - Centre for Epidemiologic Studies Depression Scale (CES-D)

Below is a list of some of the ways you may have felt or behaved. Please indicate how often you’ve felt this way during the past week. Respond to all items

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please tick the appropriate column.**During the past week…** | Rarely or none of the time (less than 1 day)  | Some or a little of the time (1-2 days)  | Occasionally or a moderate amount of time (3-4 days)  | All of the time (5-7 days) |
| 1. I was bothered by things that do not usually bother me.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 2. I did not feel like eating; my appetite was poor.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 3. I felt that I could not shake off the blues even with help from my family.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 4. I felt that I was just as good as other people.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 5. I had trouble keeping my mind on what I was doing.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 6. I felt depressed.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 7. I felt that everything I did was an effort.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 8. I felt hopeful about the future.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 9. I thought my life had been a failure.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 10. I felt fearful.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 11. My sleep was restless.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 12. I was happy.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 13. I talked less than usual.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 14. I felt lonely.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 15. People were unfriendly.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 16. I enjoyed life.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 17. I had crying spells.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 18. I felt sad.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 19. I felt that people disliked me.  | [ ]  | [ ]  | [ ]  | [ ]  |
| 20. I could not ‘get going’ | [ ]  | [ ]  | [ ]  | [ ]  |

## Section 17 – Generalised Anxiety Disorder Assessment (GAD-7)

**Over the last 2 weeks, how often have you been bothered by the following problems?**

### 1. Feeling nervous, anxious or on edge

[ ]  Not at all [ ]  Several days

[ ]  More than half the days [ ]  Nearly every day

### 2. Not being able to stop or control worrying

[ ]  Not at all [ ]  Several days

[ ]  More than half the days [ ]  Nearly every day

### 3. Worrying too much about different things

[ ]  Not at all [ ]  Several days

[ ]  More than half the days [ ]  Nearly every day

### 4. Trouble relaxing

[ ]  Not at all [ ]  Several days

[ ]  More than half the days [ ]  Nearly every day

### 5. Being so restless that it is hard to sit still

[ ]  Not at all [ ]  Several days

[ ]  More than half the days [ ]  Nearly every day

### 6. Becoming easily annoyed or irritable

[ ]  Not at all [ ]  Several days

[ ]  More than half the days [ ]  Nearly every day

### 7. Feeling afraid as if something awful might happen

[ ]  Not at all [ ]  Several days

[ ]  More than half the days [ ]  Nearly every day

### **If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

[ ]  Not difficult at all [ ]  Somewhat difficult

[ ]  Very difficult [ ]  Extremely difficult

## Section 18 – DAS 21 Scale

Please read each statement and check the box 0, 1, 2, 3, which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

*The rating scale is as follows:*

**0** Did not apply to me at all – NEVER

**1** Applied to me to some degree, or some of the time - SOMETIMES

**2** Applied to me to a considerable degree, or a good part of time - OFTEN

**3** Applied to me very much, or most of the time - ALMOST ALWAYS

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please check the appropriate column** | **0** | **1** | **2** | **3** |
| I found it hard to wind down | [ ]  | [ ]  | [ ]  | [ ]  |
| I was aware of dryness of my mouth | [ ]  | [ ]  | [ ]  | [ ]  |
| I couldn’t seem to experience any positive feeling at all | [ ]  | [ ]  | [ ]  | [ ]  |
| I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion) | [ ]  | [ ]  | [ ]  | [ ]  |
| I found it difficult to work up the initiative to do things | [ ]  | [ ]  | [ ]  | [ ]  |
| I tended to over-react to situations | [ ]  | [ ]  | [ ]  | [ ]  |
| I experienced trembling (e.g., in the hands) | [ ]  | [ ]  | [ ]  | [ ]  |
| I felt that I was using a lot of nervous energy | [ ]  | [ ]  | [ ]  | [ ]  |
| I was worried about situations in which I might panic and make a fool of myself | [ ]  | [ ]  | [ ]  | [ ]  |
| I felt that I had nothing to look forward to | [ ]  | [ ]  | [ ]  | [ ]  |
| I found myself getting agitated | [ ]  | [ ]  | [ ]  | [ ]  |
| I found it difficult to relax | [ ]  | [ ]  | [ ]  | [ ]  |
| I felt down-hearted and blue | [ ]  | [ ]  | [ ]  | [ ]  |
| I was intolerant of anything that kept me from getting on with what I was doing | [ ]  | [ ]  | [ ]  | [ ]  |
| I felt I was close to panic | [ ]  | [ ]  | [ ]  | [ ]  |
| I was unable to become enthusiastic about anything | [ ]  | [ ]  | [ ]  | [ ]  |
| I felt I wasn’t worth much as a person | [ ]  | [ ]  | [ ]  | [ ]  |
| I felt that I was rather touchy | [ ]  | [ ]  | [ ]  | [ ]  |
| I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat) | [ ]  | [ ]  | [ ]  | [ ]  |
| I felt scared without any good reason | [ ]  | [ ]  | [ ]  | [ ]  |
| I felt that life was meaningless | [ ]  | [ ]  | [ ]  | [ ]  |

## Section 19 – Personal and Household Hygiene Questionnaire

**Personal hygiene – please tick the option that applies most accurately to you**

1. Upon getting home, do you wash your hands?

[ ]  Always [ ]  Mostly [ ]  Infrequently [ ]  Never

### 2. Upon finishing a workout at a gym facility, do you wash your hands?

[ ]  Always [ ]  Mostly [ ]  Infrequently [ ]  Never

### 3. After touching a pet or other animal, do you wash your hands?

[ ]  Always [ ]  Mostly [ ]  Infrequently [ ]  Never

### 4. Before eating, do you wash your hands?

[ ]  Always [ ]  Mostly [ ]  Infrequently [ ]  Never

### 5. Before preparing food, do you wash your hands?

[ ]  Always [ ]  Mostly [ ]  Infrequently [ ]  Never

### 6. After using the toilet, do you wash your hands?

[ ]  Always [ ]  Mostly [ ]  Infrequently [ ]  Never

**Household hygiene – please tick the option that applies most accurately to you**

1. How often is your computer keyboard cleaned by you or someone else?

[ ]  Never [ ]  Once/year [ ]  2-3 times/year [ ]  Once/month [ ]  Once/week or more

### 2. How often are your bookshelves/storage bins cleaned by you or someone else?

[ ]  Never [ ]  Once/year [ ]  2-3 times/year [ ]  Once/month [ ]  Once/week or more

### 3. How often is your desk surface cleaned by you or someone else?

[ ]  Never [ ]  Once/year [ ]  2-3 times/year [ ]  Once/month [ ]  Once/week or more

### 4. How often is your television remote control cleaned by you or someone else?

[ ]  Never [ ]  Once/year [ ]  2-3 times/year [ ]  Once/month [ ]  Once/week or more

### 5. How often is your overhead light switch cleaned by you or someone else?

[ ]  Never [ ]  Once/year [ ]  2-3 times/year [ ]  Once/month [ ]  Once/week or more

### 6. How often is your dish/cup/mug cleaned by you or someone else?

[ ]  Never [ ]  Once/year [ ]  2-3 times/year [ ]  Once/month [ ]  Once/week or more

### 7. How often is your refrigerator handle cleaned by you or someone else?

[ ]  Never [ ]  Once/year [ ]  2-3 times/year [ ]  Once/month [ ]  Once/week or more

## Section 20 - Athlete Confidentiality Statement:

All sports science and medical information about you is confidential and will only be disclosed when relevant to your sports performance to members of the sports science and medical support network and designated performance team members involved in your care and acting in your interest.

You have the right to request that specific information is not shared across the networks of professional staff but unless you make a specific request for such confidentiality, we will share information about you within these networks in order to provide you with the best possible support. (Please read the Institute’s information document on information sharing).

## Section 21 - Athlete Consent Statement:

This is found in the Athlete Profile Questionnaire which must be completed prior to attending your induction at Sport Northern Ireland Sports Institute.

## Section 22 – For SNISI Sport Physician Completion only

|  |
| --- |
| **Doctor Name:** |
| **Date Questionnaire Reviewed:** |
| **Signature:** |
| **Notes:** |