

ANAMNESTIC QUESTIONNAIRE

DETAILS OF THE ATHLETE (The questionnaire is strictly personal and must be completed by the Athlete if of age, by the parent with the Athlete's data if a minor. The NO or YES check box must always be crossed).

Surname: _____ Name: _____ Age: _____

SEX: M F Ulss: _____ Identity card: _____ N°: _____

Born on: _____ birth place: _____

Resident in: _____ address: _____

Domicile in: _____ address: _____

Tel: _____ Mail: _____

Sport for which the visit is requested: _____ Club: _____

AGONISTIC

NON AGONISTIC

FAMILY HISTORY (check the boxes and enter the relationship with family member where appropriate):

Arterial hypertension	NO	YES	Who
Myocardial infarction and/or coronary artery disease	NO	YES	Who
Arrhythmias	NO	YES	Who
Valvular heart disease	NO	YES	Who
Acute ischemic stroke	NO	YES	Who
Diabetes	NO	YES	Who
Hypercholesterolemia	NO	YES	Who
Sudden death	NO	YES	Who
Genetic disorders	NO	YES	Who

ATHLETE'S MEDICAL HISTORY:

Last tetanus vaccine (date):

Profession:

Smoker NO YES How many cigarettes per day? How many years?

Coffee drinker NO YES How many a day?

Drinking habits NO YES Daily quantity?

Childhood diseases NO YES Specify which one?

Arrhythmias and congenital heart disease NO YES

Valvular heart disease NO YES

Myocardial infarction and/or coronary artery disease NO YES

Hypercholesterolemia NO YES

Diabetes NO YES

Asthma NO YES

Allergies NO YES Which one?

Arterial hypotension/hypertension NO YES If so, which one?

Hypothyroidism/Hyperthyroidism NO YES If so, which one?

Epilepsy NO YES

Traumatic brain injury NO YES When?

Flat foot NO YES Insoles?

Orthopedic shoes?

Scoliosis NO YES Use of corrective busts? Corrective gymnastics?

Spinal disc herniation and/or protrusion NO YES Use of corrective bust? Corrective gymnastics?

Other diseases NO YES Which?

Are you currently on any medication? NO YES Which one? Dose: Disease?

CARDIAC HYSTORY:

Any syncope ("faint", "collapse") at rest, during or immediately after a physical EXERCISE/EFFORT exertion? NO YES

Any palpitations? NO YES

Any shortness of breath with exertion? NO YES

Any chest pain? NO YES

Any episode of sudden heart rate acceleration with sudden return to normal? NO YES

Past injuries NO YES Which and when?

Past surgeries and/or hospitalizations NO YES Which and when?

Do you use glasses? NO YES For which refractive error?

Past eye trauma? NO YES

Past examinations for doctor sports medical certificates? NO YES If so, where was the last one? When (year)?

Have you ever been declared "INELIGIBLE"? NO YES If so, why?

Have you ever been asked for additional investigations? NO YES If so, what and why?

WOMEN ONLY:

menstrual cycle age of first menstruation _____ regular cycle irregular cycle

last menstruation date _____ menopause YES NO past pregnancies; if so, how many? _____

I, the undersigned, declare that I have correctly informed the doctor of my psychophysical conditions, that the above is true and that I have not omitted anything about previous or current illnesses or impairments. I also declare that I have not received any other opinion of "NOT SUITABILITY" to practice sports. I undertake not to use substances recognized as illegal and acknowledge that I have been informed of the dangers of tobacco smoke and alcohol abuse. (Circ. Reg. Veneto n°23694 del 20/06/1986).

I hereby: I AGREE I DO NOT AGREE

pursuant to the current privacy law, to process my personal and sensitive data for the purposes related to my request for suitability for competitive / non-competitive sports, according to the methods and procedures provided for by the laws on the health protection of the activities sports.

