COMPETITIVE SPORT PHYSICAL FITNESS EXAM

Please indicate the sport for which the physical fitness exam is requested.

The following section of the medical record must be completed by the athlete

ANAGRAPHIC DATA

First name, Last name: ____________________________ Date of birth: ____________________________

Address: (Street name, Zip Code, City): __________________________________________________________

Phone (home): ____________________________ Phone (business): ____________________________

PRACTICED SPORT

Do/did you experience any physical problems while practicing your sport? (If yes, please specify.)

How many hours per week do you spend training?

Do you do any other sports? (If yes, please indicate which sport(s) and how many hours.)

FAMILY MEDICAL HISTORY

Have anyone in your family (parents, siblings, grandparents) had (have) a history of heart disease before the age of 50?

- Myocardial infarction
  - YES ☐ NO ☐

- Sudden death
  - YES ☐ NO ☐

- Other
  - YES ☐ NO ☐

PERSONAL MEDICAL HISTORY

Have you ever been admitted to a hospital/clinic? Have you had any surgical operations, major traumatic injuries or accidents? (If yes, please explain)

Have you had any illnesses or medical problems of the following organs/systems? (which organ/when?)

(Please check the appropriate box. If you are answering “yes” to the YES, PRESENTLY or IN THE PAST boxes, please indicate the pathology.)

HEAD/NERVOUS SYSTEM

Head traumas (including cerebral commotions), dizziness, balance problems, migraines, chronic headaches, loss of consciousness, convulsions, other problems?

- YES, PRESENTLY
- NO
- IN THE PAST

PSYCHIATRIC PROBLEMS

Anxiety, claustrophobia, panic attacks, depression, other problems?

- YES, PRESENTLY
- NO
- IN THE PAST

EYES

Do you have any visual problems?

Do you wear:

- GLASSES
- CONTACT LENSES

NOSE/PARANASAL SINUSES

Hay fever, frequent nose bleeds, sinusitis, other?

- YES, PRESENTLY
- NO
- IN THE PAST
**EARS**
Otitis, tympanic perforation, humming, balance problems, loss of hearing?

| YES, PRESENTLY | NO | IN THE PAST |

**RESPIRATORY SYSTEM**
Tuberculosis, pneumonia, asthma, chronic bronchitis, light exercise or cold air induced dyspnea, other?

| YES, PRESENTLY | NO | IN THE PAST |

**CARDIOCIRCULATORY SYSTEM**
Congenital cardiac anomalies, myocarditis, angina pectoris, chest pain, arrhythmias, arterial hypertension, phlebitis, peripheral artery disease, other?

| YES, PRESENTLY | NO | IN THE PAST |

**GASTROINTESTINAL SYSTEM**
Dyspepsia, reflux and heartburn, gastric ulcers, duodenal ulcers, colics, inguinal hernias, other?

| YES, PRESENTLY | NO | IN THE PAST |

**UROGENITAL SYSTEM**
Nephritis, pyelitis, cystitis, kidney stones, other?

| YES, PRESENTLY | NO | IN THE PAST |

**SKIN, MUSCULOSKELETAL SYSTEM**
Articular rheumatism, low back pain, sciatica, herniated disc, dislocations, fractures, other?

| YES, PRESENTLY | NO | IN THE PAST |

**METABOLISM**
Hypo or hyperthyroidism, gout, diabetes mellitus, hypercholesterolemia, other dyslipidemias, anemias, other?

| YES, PRESENTLY | NO | IN THE PAST |

**RESERVED FOR FEMALE ATHLETES ONLY:**
Are you pregnant? Menstrual cycle anomalies? Presently menstruating?

| YES | YES | YES |
| NO | NO | NO |

Have (Did) you experienced any unexplained fevers in the past few months? (If yes, when?)

| YES |
| NO |

Have (Do/did) you had (have) any other illnesses not listed in this questionnaire? (If yes, please specify.)

Do you consume alcohol? (If yes, please indicate quantity.)

__________________________

Do you smoke? (If yes, what and how much?)

__________________________

Please list all your current prescribed medications (if any):

__________________________

In the past, have you ever been found UNFIT to practice any sport?

| YES | NO |

In accordance with article 13 of the Government Decree n. 196/2003 (personal data protection matter code):
The above-mentioned data has been prescribed by current regulations for the proceeding of this questionnaire only and will not be used for any other purpose. With my signature below, I hereby give my consent for the medical examination. For further information or if you have any questions please do not hesitate to contact us on www.sabes.it

If you have any questions, please contact the physician!

Date:_________________ Signature (parent’s signature required if a minor):_________________