C.M.P.

CENTRO MEDICO POLISPECIALISTICO

DIRETTORE SANITARIO DOTT. G. OSELLADORE

NAME _____ SURNAME _____
PROFESSION_____ SPORT _____

THIS IS MY FIRST SPORT VISIT YES NO
I HAVE BEEN SUBJECTED TO POST MEDICAL CHECKS YES NO
WHICH ONES: ECHOCARDIOGRAPHY
HOLTER
OTHER _____

1) DOES ANYONE IN YOUR FAMILY (PARENTS, GRANDPARENTS, BROTHERS/SISTERS) HAVE:

HEART ATTACK	YES	NO	THYROID DISEASE	YES	NO
HYPERTENSION	YES	NO	ASTHMA/ALLERGIES	YES	NO
CANCER	YES	NO	SUDDEN DEATH BEFORE AGE 50	YES	NO
DIABETS	YES	NO	BRAIN STROKE	YES	NO

2) INFORMATIONS ABOUT THE ATHLETE:

SMOKE	YES	NO	AMOUNT_____
ALCOHOL	YES	NO	AMOUNT_____
NARCOTICS	YES	NO	

3) SUFFER FROM:

WEAR GLASSES	YES	NO	
HIGH BLOOD PRESSURE	YES	NO	
ASTHMA/ALLERGIES	YES	NO	
HEART BURN	YES	NO	
ARRHYTHMIA/EXSTRASYSTOLIA	YES	NO	
INTESTINAL DISEASES	YES	NO	
DIZZINESS/ LOSS OF SENSES	YES	NO	
FRACTURES OR TRAUMAS	YES	NO	AMOUNT_____
SURGICAL INTERVENTIONS	YES	NO	AMOUNT_____
TAKE MEDICATIONS	YES	NO	AMOUNT_____
PROBLEMS DURING PHYSICAL EFFORT	YES	NO	AMOUNT_____

I,_____ parent of_____ declare under my resposability that the informations provided in the questionnaire are complete and true, and I agree to the use of personal data which will be treated in accordance with the regulation UE n.2016/679 for the purposes and methods referred to the article 13 of this regulation.

Date_____ Sign_____