AUTONOME PROVINZ BOZEN – SÜDTIROL / PROVINCIA AUTONOMA DI BOLZANO – ALTO ADIGE
PROVINZIA AUTONOMA DE BULSAN – SUDTIROL

Südtiroler Sanitätsbetrieb / Azienda Sanitaria dell'Alto Adige
Azienda Sanitera de Sudtirol

Territorialer Bereich
Betrieblicher Dienst für Sportmedizin

Area Territoriale
Servizio Aziendale di Medicina dello Sport

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?)

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** – if only one parent signs, they confirm with their signature that they have also obtained the consent of the other parent)