Questionnaire Sports Medical Examination

PERSONAL PARTICULARS

Name:

Date of birth:

Address:

Contact Number:

Blood Group:

Gender:

Weight Category:

	Yes	No
Did you have any illnesses earlier?		
Were your born with any of your body parts missing?		
Have you ever been treated in hospital?		
Do you take any medicine on a regular basis?		
Do you take any food complementary substances?		
Have you ever fainted during or after training?		
Have you ever had any chest pain?		
Have you ever had high blood pressure?		
Have you ever had any skin diseases?		
Do you have any dermatological complaints at the moment?		
Do you suffer from asthma?		
Do you have any problems related to your bones, joints, tendons, or muscles?		
Have you ever had a skull injury accompanied with a loss of consciousness?		
Did you have headache in the past 10 days?		
Do you have teeth braces? If yes please attach the medical certificate!		
Is it possible that you are pregnant?		
Are you often on a diet		

Please give further details on answers with "YES"!

I officially declare that I am fully responsible legally for my answers given above.

Date: Signature: