שרותי ספורט ורפואה

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מרכז הספורט הלאומי, איצטדיון האתלטיקה הדר יוסף, תל-אביב

smsfax@gmail.com 03-6487666 פקס 03-6497522 טל'

Passport No.	Family Name	Name		Sport Type
Address	Phone No.	Age	M / F	Height
E-mail		Med. Ins.		Weight

Questionnaire Remarks: ***(If you answered any of the above questions with Yes):

	No\ Yes
1. Was any abnormality found in your last sports check-up?	❑ ❑
2. Did you ever go through surgery or where you ever hospitalized?	❑ ❑
3. Did you ever suffer from the following diseases: Asthma/ Bronchitis/	❑ ❑
Epilepsy/ Mononucleosis/ Jaundice/ Tuberculosis/ Diabetes/ etc'	❑ ❑
4. Frequent head aches/ eye injuries/ ulcer or any other disease?	❑ ❑
5. Do you take medications at present or on a regular basis?	❑ ❑
6. Did you lose consciousness or faint during effort or after?	❑ ❑
7. Did you suffer pain or pressure in your chest during effort?	❑ ❑
8. Did you feel dizziness or extreme fatigue during effort?	❑ ❑
9. Do you suffer from high blood pressure?	❑ ❑
10. Did you ever receive a report of heart disease\a defect\heart murmur?	❑ ❑
11. Did you feel strong heart beats or the lack of heart beat?	❑ ❑
12. Did anyone in your family die of heart problems under the age of 40?	❑ ❑
13. Did you ever suffer a concussion or any other head injury?	❑ ❑
14. Smoking (at present or in the past)?	❑ ❑
15. Were you ever injured (sprain, break, dislocation) in one or more of	❑ ❑
the following: hand, palm, elbow, arm, shoulder, neck, back, hip, thigh, knee, calf, foot?	❑ ❑
16. Did you suffer from convulsions\lose consciousness during a fever?	❑ ❑
17. Did you suffer from skin problems: scratching, spots, split skin?	❑ ❑
18. Are you sensitive to or have allergies to drugs, bees etc.?	❑ ❑
19. Do you use prosthetics or supporters?	❑ ❑

20. When did you last get a Tetanus injection?_____

For women athletes only:

- At what age did you first get your menstruation? _____
- When was your last period? _____
- Is your menstruation regular? ❑ ❑

*** Remarks

Declaration: I hereby declare that the information I gave is true and fully present my medical background. I am aware that withholding information or giving wrongful information may cause me medical harm. I know that the validity of the physical activity certification is for 1 year only. In addition, I waive my rights to medical secrecy and allow a report of the results of my medical examination to be given to the sports club I belong to.

Date **Signature**