

 CENTRO MEDICO TORRE	MEDICINA DELLO SPORT MEDICAL HYSTORY FORM (anamnesis form)	CENTRO MEDICO TORRE SRL struttura sanitaria privata Aut. Sanitaria AS FO n.0040592/P del 10/10/2022
		Data: 27/10/2024
		Revisione: B

SPORTS MEDICINE – MEDICAL HISTORY FORM (ANAMNESIS FORM)

Type of examination:

☐ Competitive (Agonistic) ☐ Non-competitive

Height: _____ Weight: _____

Full Name: _____ Date of Birth: ____ / ____ / ____

Sex: ☐ M ☐ F Sport practiced: _____

• Personal Medical History

1. Pre-existing conditions

Have you ever suffered from chronic or serious illnesses?

☐ Yes ☐ No

If yes, specify: _____

2. Allergies

Do you have any known allergies (food, medications, etc.)?

☐ Yes ☐ No

If yes, specify: _____

3. Surgical procedures

Have you undergone any surgical procedures?

☐ Yes ☐ No

If yes, specify type and date: _____

4. Family hereditary diseases

Are there hereditary diseases or predispositions in your family?

☐ Yes ☐ No

If yes, specify: _____

5. Cardiovascular problems

Have you ever experienced cardiovascular issues (e.g., palpitations, chest pain, fainting)?

☐ Yes ☐ No

If yes, specify: _____

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6. Respiratory problems

Have you ever had respiratory issues (e.g., asthma, respiratory allergies)?

☐ Yes ☐ No

If yes, specify: _____

7. Musculoskeletal disorders

Have you ever had musculoskeletal problems (e.g., fractures, injuries, pain)?

☐ Yes ☐ No

If yes, specify: _____

8. Vaccination status

Are you up to date with mandatory vaccinations?

☐ Yes ☐ No

Have you received any recent vaccines (e.g., tetanus, COVID)?

☐ Yes ☐ No

9. Medication use

Do you regularly take medications?

☐ Yes ☐ No

If yes, specify type and dosage: _____

10. Use of dietary supplements

Do you take dietary supplements?

☐ Yes ☐ No

If yes, specify: _____

• Sports History (only for competitive certification)

1. Sports experience

How long have you been practicing sports? _____

Which sports have you practiced in the past? _____

2. Sports injuries

Have you had injuries related to sports activity?

☐ Yes ☐ No

If yes, specify type of injury and recovery time: _____

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3. Current training

Training frequency per week: _____ times

Average duration of each session: _____ minutes

• Lifestyle

1. Smoking

Do you smoke? ☐ Yes ☐ No

If yes, how many cigarettes per day? _____

2. Alcohol

Do you consume alcohol? ☐ Yes ☐ No

If yes, how often? _____

3. Sleep

How many hours do you sleep per night? _____

Do you have sleep problems? ☐ Yes ☐ No

4. Diet

Do you follow a specific diet (e.g., vegetarian, vegan)? ☐ Yes ☐ No

Brief description: _____

Patient Signature: _____

Date: ____ / ____ / ____

Altezza :

Peso:

Firma del Paziente: _____

Data: ____ / ____ / ____