

## IISA® MEDICAL ASSESSMENT FORM

### Section A – Swimmer - Personal Details

Full Name	Date of Birth dd/mm/yyyy	Gender	Occupation
Catharina Hoegdal	06/06/1991	M/F	Project Coordinator

Address	Ragnhildgade 50, st. th.				
City/Town	Copenhagen	Country	Denmark	Post Code	2100
Email	catharina-hoegdal@outlook.dk			Phone	+45 27627766

### Section B – Swimmer Medical History

(please circle Yes or No, if you answered yes, please give further details in the line below)

1 Past Medical History	Yes	<input checked="" type="radio"/> No
2 Past surgical history	Yes	<input checked="" type="radio"/> No
3 Current Medication	Yes	<input checked="" type="radio"/> No
4 Allergies	Yes	<input checked="" type="radio"/> No
5 Cardiovascular - e.g. high blood pressure, arrhythmias	Yes	<input checked="" type="radio"/> No
6 Parents/Siblings with cardiovascular conditions	Yes	<input checked="" type="radio"/> No
7 Respiratory –e.g. asthma	Yes	<input checked="" type="radio"/> No
8 Abdomen - GIT	Yes	<input checked="" type="radio"/> No
9 Neurological – e.g. epilepsy	Yes	<input checked="" type="radio"/> No
10 ENT (ear / nose / throat)	Yes	<input checked="" type="radio"/> No
11 Eyes – Visual problems, surgery	Yes	<input checked="" type="radio"/> No
12 Psychiatric	Yes	<input checked="" type="radio"/> No