Medical Questionnaire

Place of examination	Date
Surname, First name	Date of birth
Occupation	Nationality
Address, Postcode	Telephone
Licence applied for ☐ RY ☐ RC ☐ BA ☐ RA ☐ DR ☐ KA ☐ CD ☐ Other	Class
Club	Number of events last 12 months

Applicants medical Declaration. Please answer all questions, remember to sign below

Reported illness the last year			Cause
Do you now have or have you ever had any of the following:	No	Yes	Statements, comments
Subject to accident or incident			
Head injury with unconsciousness or concussion			
Recurrent headache or migraine			
Dizziness, fainting spells of block outs			
Nerve or muscle disease			
Nervous breakdown, mental disease or disorder			
Eye disease/impaired vision			
Squint/double vision			
Do you wear glasses or contact lenses			
Asthma, hay fever or other allergy			Medication
Diabetes			
Breathlessness at effort			
Palpitation of the heart or chest pain			
Heart or vascular disease			
High blood pressure			
Gastro- intestinal disorder			
Menstruation problems			
Disease or injury to skeleton, muscles or joints			
Neck/backpain or sciatic radiation			
Been to hospital treatment			When, cause
Of other reason consulted a doctor			
Do you use sleeping drugs or tranquilizers			
Do you use analgesics			
By a doctor prescribed other medicine or medicine on RF´s "Röda Listan" (http://www.antidoping.se/rodalistan/)			
Do you take other, prescription free, drugs			☐ Regularly ☐ When needed
Changed your body weight			Increased kgs Decreased kgs
Do you smoke			How much
Do you feel totally healthy			
Do you exercise (physical) regularly			How?
Have you been vaccinated against tetanus within the last 10 years			When?
Height cm			BMI=V/H²= (Body mass index)
Weight kgs			

I certify that the statements regarding my psychological and physical condition, and any previous illness are true and accurate and I authorise any hospital or medical practitioner to furnish information relative to my medical condition to the doctor of ASN.
I undertake that I will not use any drug considered illegal.

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Place & date ***Applicant's signature***

Medical Examination Report (Authorised)
All questions must be answered and completed by a Registered Medical Practitioner

Date of birth

Is there any evidence of abnormality in:	No	Yes	Findings, comments
Heart or cardiovascular system			
Pulmonary system			
Restriction of movement of muscles or joints			
Backbone, upper or lower limbs			
Central nervous system			
Periferal nervous system			
Mouth and throat			
Mental condition			
Restricted movement of the head sideways			
Field of vision, stereoscopic vision			
Eye movement			
Nystagmus			
Eyelids or conjunctiva, pupil reaction			
Is urine analysis normal			
Is ordinary speech level cought at 4m distance			
Blood pressure Systolic			
Diastolic			
Vision	Un-corrected	Corrected	>9/10 in each eye
Binocular			When correction is needed, always state the strength of glasses
Right Eye			st ○ cyl ax
Left Eye			st ○ cyl ax
Do you wear glasses ☐ Permanently ☐ Temporarily ☐ Contact lenses			☐ Colour vision normal ☐ Defect
Stress-related electrocardiogram (from 45 years of age) **Compulsary every second year** ☐ Done this year ☐ Not done			☐ Without comments ☐ Answer enclosed
12-lead electrocardiogram (under 45 years of age) **Compulsary every second year** ☐ Done this year ☐ Not done			☐ Without comments ☐ Answer enclosed
Has anything else appeared from examination or do you otherwise know anything about the applicant that could be of importance in judging his/her fitness to the licence stated:	☐ No	☐ Yes	
COMMENTS			
Obstacle from given medical declaration and examination report concerning driving in races	☐ Does not exist	☐ Exists	
Summerized comments:			
Doctor's signature and date	Telephone:		Clarification of signature, address, telephone business/stamp
	Telefax:		
ASN DECISION: The Applicant should before final determination be examined by a Medical Specialist in:			

Return this form to:

THE SWEDISH AUTOMOBILE SPORTS FEDERATION

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