

SPAZIOSAFARI LIMITED

Address P.O. Box 15186 - Arusha, Tanzania

Phone: Tanzanian number +255 767 819029 | Italian number +39 338 204 00 31

Email info@spaziosafari.com | Website www.spaziosafari.com

TIN Number 134-239-921

MEDICAL QUESTIONNAIRE

nameSurname						
born in/						
Weight kg height cm years o	ld					
Medical antecedents						
Have you suffered or are suffering from hypertension? of angina of chest?	□NO	□YES				
Did you have a heart attack? If so when?//	□NO	□YES				
Have you had any heart rhythm disorders? Do you have a pacemaker?	□NO	□YES				
Have you had any phlebitis?	□NO	□YES				
Did you suffer or suffer from asthma? of chronic bronchitis? emphysema? of pulmonary embolism?	□NO	□YES				
Have you (had) a stomach / duodenum ulcer? Have you (had) an esophagitis?	□NO	□YES				
Have you (had) a hiatal hernia?	□NO	□YES				
Have you (had) reflux (burning)?	□NO	□YES				
Did you have hepatitis (jaundice)? If so, which one?	□NO	□YES				
Did you suffer or suffer: from diabetes?	□NO	□YES				
thyroid?	□NO	□YES				
migraine?	□NO	□YES				
epilepsy?	□NO	□YES				
Parkinson's disease?	□NO	□YES				
Have you had a cerebral vascular accident or a head injury? Did you have any consequences? If so what?	□NO	□YES				
	\ <u>\</u>	\/FC				
Did you suffer or suffer from other illnesses? if yes, which ones?	□NO	□YES				



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Allergies

Allergies					
Did you manifest an allergy?	□NO	□YES			
At the latex?	□NO	□YES			
At a drug? If so, which one?	□NO	□YES			
At a food? If so, which one?	□NO	□YES			
At a band-aid? If so, which one?	□NO	□YES			
To a product used by the dentist?	□NO	□YES			
To a product used during a radiological examination?	□NO	□YES			
To mites / pollens / mycenae / animals	□NO	□YES			
To other things? If so, which one?	□NO	□YES			
How does the allergy manifest?	□NO	□YES			
An eczema?	□NO	□YES			
Rash?	□NO	□YES			
A conjunctivitis?	□NO	□YES			
A rhinitis?	□NO	□YES			
Of breathing difficulties?	□NO	□YES			
An important hypotension?	□NO	□YES			
Anesthesiological antecedents					
Have you already had an anesthesia?	□NO	□YES			
If yes - did you have any complications during or after anesthesia?	□NO	□YES			
If so, which one?					



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Drugs

	Di	ugs		
Do you take any medications currently?		□ N (□NO □YES	
if yo	ou complete t	the scheme be	elow	
Name of the drug	Dosage	Morning	Afternoon	Evening
	For w	omen		
take a contraceptive pill?				O "YES
are you pregnant?			□N(O •YES
	DA	ATE .		
	/	/		
	SIGNA	ATURE		
THAN	KS FOR YOUF	R COLLABORA	TION!	