PRIX DE LAUSANNE

Document to upload on the online registration form
Information form to be filled in by your attending physician

STATE OF HEALTH

Medical documents will be reviewed by the consultant-physician of the Prix de Lausanne, Dr Carlo Bagutti. Prix de Lausanne's team can be contacted at the following address:

Prix de Lausanne
Av. des Bergières 14
1004 Lausanne, Switzerland

registration@prixdelausanne.org
Tel: +41 21/648 05 25

Candidate's last name and first name:

Male ☐ Female ☐
Date of birth (day/month/year):
Candidate's medical history:
Has the candidate already experienced medical problems? yes ☐ no ☐

Diagnoses:
Parents

Name of mother:	Father's name:
Date of birth:	Date of birth:
Body weight (kg):	Body weight (kg):
Height (cm):	Height (cm):

Has the candidate already had her first menstruation? yes ☐ no ☐ n/a ☐
Age of first menstruation:
Has she had an absence of menstruation for the last three months? **yes ☐ no ☐**
Has the candidate ever suffered from a stress fracture? yes ☐ no ☐

If yes, please specify date and localization:

Allergies:
Are there known allergic reactions to certain medication or food? **yes ☐ no ☐**
If yes, please specify which:

Nutritional behaviour:
Is there any notion of disturbances in nutritional behaviour shown by the candidate now, in his/her past, or in the near family? **yes ☐ no ☐**
If yes, please give details:

Habitual diet:
☐ Varied
☐ Vegetarian
☐ Vegan
☐ No dairy
☐ No/limited carbohydrates
☐ No/limited fat
☐ Other (please specify):

Number of portions of fruit and vegetables per day:
0 to 1 ☐ 1 to 2 ☐ 2 to 3 ☐ 3 to 4 ☐ 4 to 5 ☐ 5 or more ☐

Candidate's last name and first name:

Intensity of physical activity:
Age when the candidate started dancing:
Number of hours of dance per week (average) for the last year:

Lifestyle:
Tobacco
Never smokes ☐ smokes occasionally ☐ smokes regularly ☐

Alcohol
Never drinks alcohol ☐ drinks alcohol occasionally ☐ drinks alcohol regularly ☐

Medication:
Does the candidate use medication, homeopathy or physiotherapy on an occasional or regular basis? **yes ☐** **no ☐**
If yes, please specify which:

Has he/she already used the following substances? **yes ☐** **no ☐**
(Please underline) analgesics, tranquillisers, laxatives, amphetamines, anabolics, narcotics.

Height and weight development:
Please indicate on the attached diagram the known data regarding the weight and height of the candidate during his/her growth.

Physical examination:
Is the candidate's state of health, and particularly his/her nutritional state

Satisfactory ☐ **Good ☐** **Excellent ☐**

Body weight: Kilograms **Height:** centimeters
Blood pressure: mm HG **Resting pulse:** /minute

Special or unusual features observed during physical examination:

PRIX DE LAUSANNE

Document à retourner au médecin conseil du Prix de Lausanne
Fiche de renseignements à remplir par le médecin traitant

Candidate's last name and first name:

1. At the time of completion of this survey for the Prix de Lausanne, …	
.. are you having any difficulties participating in training and performing due to injury, illness or other health problems?	❑ full participation without health problems ❑ full participation, but with health problems ❑ reduced participation due a health problem ❑ could not participate due to a health problem
.. to what extent are you modifying your training due to injury, illness or other health problems	❑ no modification ❑ to a minor extent ❑ to a moderate extent ❑ to a major extent
.. to what extent is injury, illness or other health problems affecting your performance?	❑ no effect ❑ to a minor extent ❑ to a moderate extent ❑ to a major extent
.. to what extent are you experiencing symptoms/health complaints?	❑ no symptoms / health problems ❑ to a mild extent ❑ to a moderate extent ❑ to a severe extent

2. Please select the **location of your worst musculo-skeletal complaint** (e.g. low backpain) or **injury** (e.g. shoulder sprain) you are experiencing.

❑ **no musculo-skeletal pain / complaint** or **injury** *(please go to question 5)*

❑ head	❑ shoulder (including clavicle)	❑ hip / groin
❑ neck / cervical spine	❑ upper arm	❑ thigh
❑ chest / ribs	❑ elbow	❑ knee
❑ thoracic spine / upper back	❑ forearm	❑ lower leg / Achilles tendon
❑ abdomen	❑ wrist	❑ ankle
❑ lumbar spine / lower back	❑ hand	❑ foot / toes
❑ pelvis / buttock	❑ fingers / thumb	❑ other, specify _____

2a. Is this complaint / injury **caused by dancing**?

❑ no ❑ yes ❑ don´t know

2b. Is this complaint / injury **new, recurrent or chronic**?

❑ new (you never had this before) ❑ recurrent after full recovery ❑ worsening /chronic

3. Please select the **location of your second worst musculo-skeletal complaint** or **injury** you are experiencing.

❑ **no further musculo-skeletal pain / complaint** or **injury** *(please go to question 5)*

❑ head	❑ shoulder (including clavicle)	❑ hip / groin
❑ neck / cervical spine	❑ upper arm	❑ thigh
❑ chest / ribs	❑ elbow	❑ knee
❑ thoracic spine / upper back	❑ forearm	❑ lower leg / Achilles tendon
❑ abdomen	❑ wrist	❑ ankle
❑ lumbar spine / lower back	❑ hand	❑ foot / toes
❑ pelvis / buttock	❑ fingers / thumb	❑ other, specify _____

3a. Is this complaint / injury **caused by dancing**?

❑ no ❑ yes ❑ don´t know

3b. Is this complaint / injury **new, recurrent or chronic**?

❑ new (you never had this before) ❑ recurrent after full recovery ❑ worsening /chronic

4. Please select the **location of your third worst musculo-skeletal complaint or injury** you are experiencing.

❑ **no further musculo-skeletal pain / complaint** or **injury** *(please go to question 5)*

❑ head	❑ shoulder (including clavicle)	❑ hip / groin
❑ neck / cervical spine	❑ upper arm	❑ thigh
❑ chest / ribs	❑ elbow	❑ knee
❑ thoracic spine / upper back	❑ forearm	❑ lower leg / Achilles tendon
❑ abdomen	❑ wrist	❑ ankle
❑ lumbar spine / lower back	❑ hand	❑ foot / toes
❑ pelvis / buttock	❑ fingers / thumb	❑ other, specify _____

4a. Is this complaint / injury caused by dancing?

❑ no ❑ yes ❑ don´t know

4b. Is this complaint / injury **new, recurrent or chronic**?

❑ new (you never had this before) ❑ recurrent after full recovery ❑ worsening /chronic

5. Please select all other **physical complaints** (e.g. headache, menstrual pain) or **illnesses** (e.g. influenza, diarrhoea) you are currently experiencing.

❑ **no illnesses** or **physical complaints**

❑ allergy, e.g. hay fever	❑ diarrhoea, nausea, vomiting	❑ heart palpations
❑ asthma	❑ headache, migraine	❑ fatigue, lack of energy
❑ flu, influenza, sinusitis, cold, cough	❑ menstrual pain / cramps	❑ others, specify _____

Place and date: **Doctor's signature and stamp:**

Name and address of attending physician (in Western characters in order to be able to write back if additional information seems necessary):

E-mail:
Phone:
Fax: