



MEDICAL QUESTIONNAIRE

NAME : MAGNUSSON

DATE OF BIRTH : 28/02/1968

LEVEL OF PRACTICE of hemispherical skydiving
at low altitude:

- Level 1 (< 20 jumps)
- Level 2 (21/40 jumps)
- Level 3 (> 40 jumps)

FIRST NAME : STEFAN

PLACE OF BIRTH : VÄXJÖ, SWEDEN

NUMBER OF JUMPS * : 128

*You must be able to justify these jumps on
presentation of proof (ex: jumps booklet)

1*) Have you ever had surgery? If yes specify <u>prostate surgery</u>	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO
2*) Have you ever had a head injury? If yes, specify (date and consequences)	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
3*) Have you suffered a spinal compression injury?	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
4*) Do you have a chronic illness? If yes specify	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
5*) Have you ever had one or: <ul style="list-style-type: none">• Fracture : when _____ location _____• Sprain : when _____ location _____• Dislocation : when _____ location _____	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
6*) Do you follow a one-time, recurring or regular drug treatment? If yes specify	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
7*) In the past 12 months have you experienced chest pain, palpitations, unusual shortness of breath or malaise? If yes specify	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
8*) Did a member of your family die suddenly of a cardiac or unexplained cause?	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
9*) Have you ever had an episode of wheezing (asthma type)	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
10*) Do you have sight problems? If yes, do you wear glasses or contact lenses:	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
11*) Do you have hearing problems? If yes, do you wear a hearing aid :	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO
12*) Do you have useful information to communicate:	<input type="checkbox"/> YES	<input checked="" type="checkbox"/> NO

I, the undersigned (surname/first name) STEFAN

I certify on my honor the accuracy and sincerity of the information given above.

Made in MÄNSÅS, SWEDEN The 23/07/2025 signature : Stefan