# MEDICAL QUESTIONNAIRE

**NAME :** Deshayes **FIRST NAME :** Claes

**DATE OF BIRTH :** 28 / 12 / 1961 **PLACE OF BIRTH :** Uddevalla, Sweden

**LEVEL OF PRACTICE** of hemispherical skydiving at low altitude:

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

**NUMBER OF JUMPS * :** 73

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

| | |
|---|---|
| **1°) Have you ever had surgery?** If yes specify _____ | **YES** **NO** |
| **2°) Have you ever had a head injury?** If yes, specify (date and consequences)_____ | **YES** **NO** |
| **3°) Have you suffered a spinal compression injury?** | **YES** **NO** |
| **4°) Do you have a chronic illness?** If yes specify _____ | **YES** **NO** |
| **5°) Have you ever had one or:** • **Fracture** : when _____ location _____ • **Sprain** : when_____ location _____ • **Dislocation :** when_____ location _____ | **YES** **NO** |
| **6°) Do you follow a one-time, recurring or regular drug treatment?** If yes specify _____ | **YES** **NO** |
| **7°) In the past 12 months have you experienced chest pain, palpitations, unusual shortness of breath or malaise?** If yes specify _____ | **YES** **NO** |
| **8°) Did a member of your family die suddenly of a cardiac or unexplained cause?** | **YES** **NO** |
| **9°) Have you ever had an episode of wheezing (asthma type)** | **YES** **NO** |
| **10°) Do you have sight problems?** If yes, do you wear glasses or contact lenses:_____ | **YES** **NO** |
| **11°) Do you have hearing problems? If yes, do you wear a hearing aid :**_____ _____ | **YES** **NO** |
| **12°) Do you have useful information to communicate:**_____ _____ | **YES** **NO** |

I, the undersigned (surname/first name) _____

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

Made in Gullholmen Sweden The 11 / 08 / 2025 signature : C. Deshayes