Centro di Ateneo per la tutela e promozione della salute e sicurezza
Servizio per la salute e la sicurezza della persona nei luoghi di lavoro
UNITA' SPECIALISTICA DI MEDICINA DEL LAVORO

Medical history form for activities in archaeological excavations

Surname: _____

Name: _____

Date of birth: /____ /____ /_____

Place of birth: _____

Height: _____ cm

Weight: _____ Kg

Student who will participate in archaeological excavations promoted and directed by faculty members of the Department of History Cultures and Civilizations at the University of Bologna.

Do you suffer or have you ever suffered from any of the following health problems?

Congenital diseases	❑ No ❑ Yes (*please specify*) _____
Tumours	❑ No ❑ Yes (*please specify*) _____
Respiratory diseases	❑ No ❑ Yes (*please specify*) _____
Cardiovascular disease	❑ No ❑ Yes (*please specify*) _____
Neurological and neuromuscular diseases	❑ No ❑ Yes (*please specify*) _____
Skin diseases	❑ No ❑ Yes (*please specify*) _____
Allergies	❑ No ❑ Yes (please specify) _____ **Have you ever had severe allergic reactions (anaphylaxis)?** ❑No ❑ Yes (*please specify*) _____ _____ _____ _____
Endocrine-metabolic diseases	❑ No ❑ Yes (please specify) _____ **For diabetics indicate whether on insuline therapy?** ❑ No ❑ Yes

Eye/ear diseases	❑ No ❑ Yes (*please specify*) _____
Musculoskeletal diseases	❑ No ❑ Yes (*please specify*) _____
Psychological disorders	❑ No ❑ Yes (*please specify*) _____
Coagulation disorders	❑ No ❑ Yes (*please specify*) _____
Other diseases	❑ No ❑ Yes (*please specify*) _____

Have you ever had surgery? ❑ No ❑ Yes (please specify) _____

_____

_____

Are you currently taking medication? ❑ No ❑ Yes (please specify) _____

_____

_____

Aware of the responsibilities and civil and penal consequences, provided for in case of false declarations and/or formation or use of false documents, also pursuant to and in accordance with art. 76 of Presidential Decree 445/2000 and subsequent amendments and additions, as well as in case of the exhibition of documents containing data no longer corresponding to the truth, I declare that I have provided all the information in my knowledge useful to define my state of health.
The undersigned also undertakes to inform and document to the Physician in charge any changes in the state of health.

Date: /____ /____ /_____

Signature of the student

_____

Signature of the competent physician

_____