HEALTH-REPORT FORM

(Self checklist for health condition for a participant of Tour de Okinawa who is 70+ years old.)

This halth-report form is designed to be used by participants who are 70 years old or older. It is important to know the overall condition of your health and, if necessary, consult to your doctor about the participation to the bicycle event. If you have not received any physical examination for the last 12 months, we recommend that you receive PE before the event. We will review your Health-Report Form and might ask you to have PE at a medical institution and submit a health certificate.

Which race/cycling category are you planning to participate? (_____)

Please circle (Yes or No) for each of the following conditions.

【1】Your Medical History	
I have high blood pressure.	Yes ・ No
I have low blood pressure.	Yes ・ No
I have dieabetes/high blood sugar level.	Yes ・ No
I have angina pectoris/arteriosclerosis.	Yes ・ No
I have hypertrophy of the heart.	Yes ・ No
I have electrocardiogram abnormality/heart murmur.	Yes ・ No
I have abnormal cardiac rhythm.	Yes ・ No
I have had a cerebral stroke before.	Yes ・ No
I have anemia.	Yes ・ No
I have bronchitis/Asthma	Yes ・ No
I have joint problem or pains in joints.	Yes ・ No
I have chronic hepatitis.	Yes ・ No
I have epilepsia.	Yes ・ No

If you have disease/disability other than those listed above, please write in the space.

(Injury/Disease/Disability:_____ since / at the age of _____.)

(Current medication if you take any:_____)

【2】Your Physical Constitution	
I am allergic to certain substances.	Yes ・ No
I can easily catch cold or have high fever.	Yes ・ No
I feel chest pains and have shortness of breath when I am active.	Yes ・ No
I can easily get a rash (eczema) on my skin.	Yes ・ No
I am prone to noseblood.	Yes ・ No

【3】Result of the Most Recent Medical Checkup	
Whan was the last time you had a medical checkup?	Yes ・ No
Date of Checkup: Year Month Day	
Medical Institution:	Yes ・ No
Diagnosis: (Normal ・ Needs re-screen ・ Refered to a doctor)	

Note that it is your responsibility to maintain your health condition regardless of the conditions you reported above.

Date of filling in the form: Year / Month / Date .

(Sign) _____