GOLF EXTRA

NAME_____ BIRTH DATE_____ SEX

OCCUPATION_____
PROFESSIONAL REFERRAL_____

PLEASE CHECK THE YES OR NO AND COMMENT ON ALL YES ANSWERS.

	Y OR N	COMMENTS
1. Have you ever:		
Been hospitalized	( ) ( )	_____
Had surgery	( ) ( )	_____
Broken a bone	( ) ( )	_____
Had a muscle injury	( ) ( )	_____
Injured the back	( ) ( )	_____
Injured a joint	( ) ( )	_____
Knee( ) Shoulder( ) Ankle( ) Elbow( ) Wrist( ) Other ( )		
2. Has anyone in your immediate family ever had:		
Diabetes (high blood sugar)	( ) ( )	_____
Sudden death (age <50)	( ) ( )	_____
High blood pressure	( ) ( )	_____
Asthma	( ) ( )	_____
High cholesterol	( ) ( )	_____
3. Have you ever had or do you now have:		
Chest pain with or after you exercise	( ) ( )	_____
Dizziness with or after you exercise	( ) ( )	_____
High blood pressure	( ) ( )	_____
Racing of the heart/irregular rhythm	( ) ( )	_____
Wheezing cough with exercise	( ) ( )	_____
Weakness, fatigue or anemia	( ) ( )	_____
Hearing loss/ perforated ear drum	( ) ( )	_____
Headaches or migraines	( ) ( )	_____
Dental plate or orthodontic work	( ) ( )	_____
Impaired vision	( ) ( )	_____
Wear glasses/ contacts	( ) ( )	_____
Hernia	( ) ( )	_____
Loss of any paired organ	( ) ( )	_____
Weight problem (under or overweight)	( ) ( )	_____
Menstrual problem (female)	( ) ( )	_____

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4. Have you ever had:	Y	N	Comments
Loss of consciousness	( )	( )	_____
Concussion	( )	( )	_____
Convulsions, seizures, or epilepsy	( )	( )	_____
Neck injury	( )	( )	_____
"Stinger", "burner", or "pinched nerve"	( )	( )	_____
Heat exhaustion or intolerance	( )	( )	_____
Heart attack	( )	( )	_____
Stroke	( )	( )	_____
5. Have you in the past or do you currently use:			
Cigarettes, chewing tobacco, or snuff	( )	( )	_____
Marijuana	( )	( )	_____
Alcohol	( )	( )	_____
Recreational drugs	( )	( )	_____
Steroids	( )	( )	_____
Ergogenic aids, vitamins or supplements	( )	( )	_____
Weight loss medications, laxatives	( )	( )	_____
Self induced vomiting	( )	( )	_____
Thyroid medication	( )	( )	_____
Sedatives, tranquilizers	( )	( )	_____
Sleeping pills	( )	( )	_____
6. Do you:			
Walk or ride when you play a round of golf?	( )	( )	_____
Exercise adequately (other than golf)	( )	( )	_____
Average 7-8 hours of sleep per night	( )	( )	_____
Participate in sports (other than golf)	( )	( )	_____
7. Have you ever had:			
Ekg	( )	( )	_____
Pulmonary function test	( )	( )	_____
Cardiac stress test	( )	( )	_____
Body fat analysis	( )	( )	_____

8. **List any current medications (incl over the counter, birth control, aspirin)**
_____
_____

9. **List any allergies** _____
10. **List any major medical problems not already mentioned** _____
_____
11. What is you main weakness with your golf game? _____
_____
12. **What is your goal by having this evaluation?** _____
_____