

## GOLF MEDICAL HISTORY FORM

### QUESTIONS:

1. Will you be involved in an outside weight-training program when training with the Whole in One Golf Program?  
 Yes       No
2. Will you be competing in a sport when training with the Whole in One Golf Program?  Yes       No  
 a. If Yes, what sport \_\_\_\_\_; how many practices/games a week \_\_\_\_\_
3. What physical activities have you been doing in the last two months? (explain)

\_\_\_\_\_

4. Are you taking any medications and/or supplements? \_\_\_\_\_

5. Do you wish to gain or lose weight?       Gain       Lose  
Why? \_\_\_\_\_

6. Has your physician advised you to avoid any types of exercise? If yes, please explain \_\_\_\_\_

### HEALTH HISTORY:

*Family History – Please check if applies to you or your family*

- Asthma
- Allergies
- High Blood Pressure
- Heart Conditions
- Dizziness with exercise
- Diabetes
- Epilepsy
- Cancer
- Anemia
- Respiratory Problems
- Sudden Death before 50
- Heat/Cold Problems
- Other

*Musculoskeletal History – Please check if applies to athlete*

- Head
- Neck
- Shoulder
- Elbow and Wrist
- Hand and fingers
- Back
- Hip
- Knee
- Ankle
- Feet and Toes
- Fractures
- Ligament Sprains
- Muscle Strains

Please explain who this affects in your family:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please explain when this occurred, left or right side, and if you have any current issues with it:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The information that I provided is correct to the best of my knowledge.

\_\_\_\_\_  
Signature of Athlete      Date

\_\_\_\_\_  
Signature of Parent/Guardian      Date

Staff Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date \_\_\_\_\_