Pre-Participation Evaluation
Data Collection
CONFIDENTIAL

DATE:			
Name:			
Address: (incl Post Code/)			
Contact:	Mobile:		
	Email:		
Tour Cards held:			
Sex	M □ F □	Date of Birth (DOB):	
Hand Dominance: **Lead Side:**			
Physician: Name, Address, Office number, email, fax			
Coach – Contact Details:			
Physiotherapist – Contact Details			
FAMILY HISTORY	***(Please circle)***		
Has anyone in your family ever suffered from any of the following?		Sudden death – under 50 years of age	
High blood pressure		Heart problems	
Asthma		Chest problems	
Diabetes		Epilepsy	
Skin cancer		Stroke	
Other - Please give details			
Doctor's Comments:			
VACCINATIONS	***(Please tick if you have had the following vaccinations)***		
Tetanus	Date	Polio	Date
MMR	Date	BCG	Date
Hepatitis A	Date	Hepatitis B	Date
Meningitis	Date	I don't have this information	
Other (*specify*):			
Have you had any travel vaccinations?	YES □ NO □	If yes, specify (i.e. Eg. Typhoid, Yellow Fever, others)	

MEDICATIONS (List all currently being taken, whether prescribed by your GP or bought over-the-counter) Please bring to medical with you		
Name	Dose	TUE needed (Y/N)
Do you, or have you taken any supplements? If so, please provide information.		
Supplement Company	Name	Frequency of use
Further information might be required on the product manufacturer		
Do you have any allergies?	YES □ NO □	If yes, please give details:

INJURY HISTORY			
DATE	INJURY	TREATMENT	100% RECOVERY (Y/N)
SURGERY HISTORY			
DATE	INJURY	TREATMENT	100% RECOVERY (Y/N)

TRAINING HISTORY	
Specific training types (range/ round)	
Recent change in training type or intensity	
Warm up procedures/time	
Cool down procedures/time	
Long term goals	
Short term goals	

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TRAVEL PLANNED	Dates
Travel advice -Time zones -DVT avoidance -Nutrition -Sleep aids/ travelpack	

PAST MEDICAL HISTORY (PMH) Have you ever suffered from any of the following?)	
Cardiovascular diseased	
Lung Diseases or Respiratory problems	
Liver Diseases	
Gastrointestinal	
Genitourinary	
Central Nervous System	
Endocrine	
Menstruation	
Ent	
Eyes	
Other	

SOCIAL HISTORY	
Tobacco Usage YES □ No □	Illicit drugs YES □ No □
Alcohol Consumption YES □ No □	Frequency
Caffeine consumption YES □ No □	Frequency

NUTRITION
Do you have any dietary restrictions such as food sensitivities or allergies?
Comments:

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PHYSICAL EXAMINATION			
Height (specify cm or inches)		Weight (specify Kg or Pounds/llbs)	
CARDIO RESPIRATORY			
Blood pressure		Pulse Bpm	
Heart sounds		Apex	
Lungs		Peak flow	
ABDOMEN			
Tenderness		Genetalia	
Heniae		Lymphadenopathy	
Organomegaly			
CENTRAL NERVOUS SYSTEM			
Power		Sensation	
Reflexes		Others	
SKIN:			
VISION:			
Acuity □		Colour Blindness □	
SPECIFIC BLOOD ANALYSIS (At the examiner's discretion)			
PHYSICIAN'S COMMENT:			
Physician Name (print)	Signature		Date

I (*name*)……………………………………………have given information to the best of my knowledge. I understand that I should ask the Medical professionals involved if there are any aspects I need explained. I also understand that this profile is being carried out in order to identify possible areas that need to be addressed in order to minimise risk of illness and/or injury during golf. I realise that it is not possible to remove those risks entirely and I agree that the professionals involved in the examination and the (…name of event…) accepts no responsibility for any such illness or injury.

Athlete Signature	Date

Recommendations/ Referrals
1.
2.
3.
4.
5.
6.
7.
8.