

Paragolfer Medical Disclosure Checklist

Please complete the form below as accurately as you can.

Questions	Response
First Name:	
Surname:	
Street:	
Town/Suburb:	
State:	
Postcode:	
Country:	
Contact Telephone:	
Email Address:	
Height in cm:	
Weight in kg:	
Age:	
Sex:	Male Female
Do you currently have OR have a history of:	Respiratory problems Diabetes Hypertension Neurological disorders or epilepsy Seizures Dizziness or fainting
Do you have any other health complaint that we should know about?:	
Do you have any Cardiac problems?:	Yes No

Questions	Response
Have you ever had any form of heart implant device such as valve or ASD closure?:	Yes No
Do you currently have OR a history of:	High blood pressure Cardiovascular disease Obesity Family history of cardiac disease Unexplained chest pain Shortness of breath Palpitations
If you checked any of the boxes in the above question, please explain details & date of injury:	
Are you allergic to:	
Are you allergic to any medications?:	Yes No
Have you ever had heat stroke or a heat related illness?:	Yes No
Do you currently do any other exercise? If so, what and how often?	
Do you smoke?:	Yes No
I have read the DISCLOSURE STATEMENT prior to completing this form and advise that information provided is true and correct:	Yes No