INTERIM FORM E--NIAA HEALTH QUESTIONNAIRE

This evaluation is only to determine readiness for sports participation. It should not be used as a substitute for regular health maintenance examinations. A positive response to any of the following questions requires a medical examination before activity can resume.

NAME: _____ AGE:_____GRADE: _____ DATE:_____

ADDRESS: _____ PHONE:_____

SPORT(S): _____

DATE OF LAST **COMPLETE** SPORTS PHYSICAL: WHERE:

STOP---Read this first------: ***In the last year*** :

		YES	NO
1.	Have you had a medical illness or injury that required you to visit a physician and miss FIVE or more consecutive days of school or sports?	_____	_____
2.	Have you been hospitalized overnight for any reason?	_____	_____
3.	a. Have you passed out or been dizzy with exercise?	_____	_____
	b. Have you had chest pain (or pressure) with exercise?	_____	_____
	c. Have you had excessive, unexplained shortness of breath or fatigue with exercise?	_____	_____
	d. Has someone in your family died, or developed serious problems due to heart disease who was younger than 50 years old?	_____	_____
	e. Have you learned of anyone in your family who has any history of hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT syndrome or Marfan's syndrome?	_____	_____
4	a. Have you had a head injury or concussion?	_____	_____
	b. Have you been knocked out, become unconscious, or lost your memory?	_____	_____
	c. Have you had a seizure?	_____	_____
	d. Have you developed frequent or severe headaches?	_____	_____
	e. Have you developed numbness or tingling in your arms, hands, legs, or feet?	_____	_____
5.	Have you become sick from exercising in the heat?	_____	_____
6.	Have you developed a cough, wheeze, or have trouble breathing during or after activity?	_____	_____
7.	Have you started requiring any special protective or corrective equipment or devices that aren't usually used for your sport or position *(for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)?*	_____	_____
8.	a. Have you had any new problems with your eyes or vision, *other than requiring glasses or contacts?*	_____	_____
	b. Have you started wearing glasses, contacts, or protective eyewear**? REMEMBER—**		
	c. **<u>This is In the last year!</u>** If you have been wearing glasses longer, check NO.	_____	_____

9. Have you had any problems with sprains, dislocations, fractures, pain or swelling in the following muscles, tendons, bones, or joints? _____ _____
If yes, check the appropriate item below:

_____ Head	_____ Elbow	_____ Hip
_____ Neck	_____ Forearm	_____ Thigh
_____ Back	_____ Wrist	_____ Knee
_____ Chest	_____ Hand	_____ Shin/Calf
_____ Shoulder	_____ Finger(s)	_____ Ankle
_____ Upper Arm	_____ Foot	_____ Toe(s)

_____

10. Would you like to talk to someone about stress, anger, depression or other issues? _____ _____

11. Have you developed any new allergies (*for example, to pollen, medicine, food or stinging insects*)? _____ _____
_____ _____

FEMALES ONLY

12. Have your periods changed (just stared, irregular, etc.)? _____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

_____ _____ _____
signature of athlete *signature of parent/guardian* *date*

Health Coordinator/School Nurse Review Only:

_____ Cleared for participation with no restrictions _____ Referred for general physical exam

_____ Referred for specialty exam/review _____ Cleared for participation (*post-physical)* Date:_____

Comments:_____

_____ Signature_____

Revised May 2001