

HEALTH RISK SCREENING QUESTIONNAIRE

CADET NAME: _____

SCHOOL NAME: _____

Date of cadet's most recent pre-participation sports physical: _____

PART A – TO BE COMPLETED BY THE CADET AND PARENT/GUARDIAN

(Circle the appropriate response to **EACH** question)

- | | | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Have you had a medical illness, injury or surgery since your last check up or sports physical? | Yes | No |
| 2. Do you have difficulty doing strenuous (great effort) exercise? | Yes | No |
| 3. Do you have a medical notice from your physician to NOT to participate in long distance runs, such as a 1-mile-run? | Yes | No |
| 4. Do you have a medical notice from your physician that you are NOT to do curl-ups or push-ups? | Yes | No |
| 5. Do you exercise less than three times per week for at least thirty minutes? | Yes | No |
| 6. Have you had any broken bones, a serious accident, or <u>any type of</u> surgery in the last six months? | Yes | No |
| 7. Do you use tobacco of any kind? | Yes | No |
| 8. Have you experienced chest, neck, jaw or arm discomfort while doing physical activity? | Yes | No |
| 9. Do you have difficulty breathing or have sudden breathing problems at night? | Yes | No |
| 10. Has Asthma ever been documented in any of your medical records growing up? | Yes | No |
| 11. Do you currently have Asthma? | Yes | No |
| 12. Are you using an inhaler to aid in breathing? | Yes | No |
| 13. Do you experience any shortness of breath with relatively low levels of exercise or exertion? | Yes | No |
| 14. Have you felt any chest pain at rest? | Yes | No |
| 15. Do your medical records contain any known cardiac (heart) disease? | Yes | No |
| 16. According to the Navy's height/weight table published on line at: https://www.navycs.com/navyheightweightchart.html are you overweight? | Yes | No |
| 17. Has your physicians limited any activity due to dizzy/fainting spells, frequent headaches, or frequent back pains? | Yes | No |
| 18. Have you ever experienced dehydration after strenuous physical exercise that has resulted in your physician now recommending or limiting certain physical activities? | Yes | No |
| 19. Are you currently under treatment by a physician or other medical practitioner? | Yes | No |
| 20. Has your mother or sister died without any explanation or suffered a heart attack before the age of 55? | Yes | No |
| 21. Has your father or brother died without any explanation or suffered a heart attack before the age of 45? | Yes | No |

- | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|------------|-----------|
| 22. Do you have high blood pressure or are you on blood pressure medication? | Yes | No |
| 23. Has a doctor ever told you that you have high cholesterol or are you on cholesterol medication? | Yes | No |
| 24. Do you have diabetes? | Yes | No |
| 25. Have you experienced episodes of rapid beating or fluttering of the heart? | Yes | No |
| 26. Do you suffer from lower leg swelling of both legs? | Yes | No |
| 27. Is there any history of metabolic disease (thyroid, renal, liver) listed in any of your medical records? | Yes | No |
| 28. Do you have a bone, joint, or muscle problem that prevents you from doing strenuous exercises? | Yes | No |
| 29. Have you unintentionally lost/gained more than 10 percent of your body weight since your last PFA? | Yes | No |
| 30. Have you ever been diagnosed with Sickle Cell Trait? | Yes | No |
| 31. Do you have a current prescription for epinephrine (or "epi" pen) for situational use? | Yes | No |
| 32. Are you currently taking any prescription or non-prescription (over the counter) medications or pills? | Yes | No |
| 33. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters, pressure sores, or bites) <u>of any kind</u> ? | Yes | No |
| If Yes , Please specify: _____ | | |
| 34. Have you ever become ill from exercising in the heat? | Yes | No |

Cadet Signature/Date

Parent/Guardian Signature/Date

PART B – TO BE COMPLETED BY A LICENSED MEDICAL PRACTITIONER

(If any of the answers to the questions above were **YES**, the following section must be completed and signed by a licensed medical practitioner)

1. List significant clinical history and/or current medication and treatment regimen of the above cadet: (Use below as necessary)

2. Recommended/released for participation in strenuous physical activities including the mile run.

Yes **No**

Signature of Medical Practitioner

Date