

HEALTH RISK SCREENING QUESTIONNAIRE

CADET NAME: _____

SCHOOL NAME: _____

Date of cadet's most recent preparticipation sports physical: _____

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

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

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|---|-----|----|
| 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 Sickie 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