INTERIM NIAA HEALTH QUESTIONNAIRE - FORM E

This evaluation should be completed only if you have a physical on file from last year.

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 (PPE): _____ WHERE: _____

SINCE YOUR LAST COMPLETE PREPARTICIPATION EXAM (PPE):

		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	_____	_____
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 hypertropic 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)?	_____	_____

Over >

		YES	*NO*
8.	Have you had any problems with your eyes or vision, other than requiring glasses or contacts?	_____	_____
9.	Have you had any problems with sprains, dislocations, fractures, pain or swelling in the following muscles, tendons, bones, or joints that currently bother you?	_____	_____

If yes, check 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 a physician about your weight, about stress, anger, depression or any other issues?	_____	_____

FEMALES ONLY

11.	If you have been having periods for one year or longer, have they become less regular?	_____	_____

IF YOU ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PLEASE SEE YOUR PHYSICIAN FOR A COMPLETE PHYSICAL.

12. Have you developed any new allergies (for example, to pollen, medicine, food, or stinging insects)? If so, please list:

_____

_____

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

Approved: February 2000: REVISED May 2001; June, 2002; June 2012, March 2023