

## INTERIM FORM E--NIAA HEALTH QUESTIONNAIRE

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

This form is only to determine readiness for sports participation. It is not to be used as a substitute for regular health maintenance examinations. A "yes" response to any of the following questions requires a new physical or a note/release from your doctor before you can practice or play.

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 ( <i>for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid</i> )?	_____	_____
8. a. Have you had any new problems with your eyes or vision, <i>other than requiring glasses or contacts</i> ?	_____	_____
b. Have you started wearing glasses, contacts, or protective eyewear? <b>REMEMBER—</b> <b><u>This is In the last year!</u></b> 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  
\_\_\_\_\_ Neck  
\_\_\_\_\_ Back  
\_\_\_\_\_ Chest  
\_\_\_\_\_ Shoulder  
\_\_\_\_\_ Upper Arm

\_\_\_\_\_ Elbow  
\_\_\_\_\_ Forearm  
\_\_\_\_\_ Wrist  
\_\_\_\_\_ Hand  
\_\_\_\_\_ Finger(s)  
\_\_\_\_\_ Foot

\_\_\_\_\_ Hip  
\_\_\_\_\_ Thigh  
\_\_\_\_\_ Knee  
\_\_\_\_\_ Shin/Calf  
\_\_\_\_\_ Ankle  
\_\_\_\_\_ 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*)? \_\_\_\_\_  
If so, list here: \_\_\_\_\_

**FEMALES ONLY**

12. Have your periods changed (just started, 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 August 2016*