NIAA / WCSD HEALTH QUESTIONAIRE / INTERIM FORM

This evaluation should be completed only if you have a physical on file from last year.
(Typically an athlete's 2nd and 4th years of athletic participation.)

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. Additionally, if a positive response has been made, both Form B (green) and Form D (blue) must be completed in full.

NAME: _____ AGE: _____ GRADE: _____ DATE: _____

ADDRESS: _____ PHONE: _____

SPORT(S): _____

DATE OF LAST COMPLETE SPORTS PHYSICAL (PPE): _____ WHERE: _____

SINCE YOUR LAST COMPLETE PPE:	YES	NO
1. Have you had an 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 that 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?	____	____

SINCE YOUR LAST COMPLETE PPE:

	YES	NO
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 aide)?	____	____
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, fractions, pain or swelling in the following muscles, tendons, bones, or joints **that continue to 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?**	____	____
11. Have you developed any new allergies (for example to pollen, medicine, food, or stinging insects)? If so, please list them:		

_____

FEMALES ONLY

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

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 2006; February 2009;