

## NIAA / WCSD HEALTH QUESTIONNAIRE / INTERIM FORM

This evaluation should be completed only if you have a physical on file from last year.  
(Typically an athlete's 2<sup>nd</sup> and 4<sup>th</sup> 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, fractures, 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;