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.

<table>
<thead>
<tr>
<th>NAME:</th>
<th>AGE:</th>
<th>GRADE:</th>
<th>DATE:</th>
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<tbody>
<tr>
<td>ADDRESS:</td>
<td>PHONE:</td>
<td>SPORT(S):</td>
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<tr>
<td>DATE OF LAST COMPLETE SPORTS PHYSICAL (PPE):</td>
<td>WHERE:</td>
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**SINCE YOUR LAST COMPLETE PREPARTICIPATION EXAM (PPE):**

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?  
   **YES**  **NO**
2. Have you been hospitalized overnight  
   **YES**  **NO**
3. a. Have you passed out or been dizzy with exercise?  
   **YES**  **NO**  
   b. Have you had chest pain (or pressure) with exercise?  
   **YES**  **NO**  
   c. Have you had excessive unexplained shortness of breath or fatigue with exercise?  
   **YES**  **NO**  
   d. Has someone in your family died, or developed serious problems, due to heart disease who was younger than 50 years old?  
   **YES**  **NO**  
   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?  
   **YES**  **NO**
4. a. Have you had a head injury or concussion?  
   **YES**  **NO**  
   b. Have you been knocked out, become unconscious, or lost your memory?  
   **YES**  **NO**  
   c. Have you had a seizure?  
   **YES**  **NO**  
   d. Have you developed frequent or severe headaches?  
   **YES**  **NO**  
   e. Have you developed numbness or tingling in your arms, hands, legs, or feet?  
   **YES**  **NO**
5. Have you become sick from exercising in the heat?  
   **YES**  **NO**
6. Have you developed a cough, wheeze, or have trouble breathing during or after activity?  
   **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 aid)?  
   **YES**  **NO**

*Over >*
8. Have you had any problems with your eyes or vision, other than requiring glasses or contacts?  

YES  NO

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?  

YES  NO

FEMALES ONLY

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

YES  NO

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