

# HEALTH RISK SCREENING QUESTIONNAIRE

CADET NAME: \_\_\_\_\_

SCHOOL NAME: Cleveland Junior Naval Academy

Date of cadet's most recent pre-participation sports physical: \_\_\_\_\_

## PART A – TO BE COMPLETED BY THE CADET AND PARENT/GUARDIAN

(Circle the appropriate response to **EACH** question)

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|---|-----|----|
| 1. Have you had a medical illness, injury or surgery since your last check up or sports physical?   | Yes | No |
| 2. Do you have difficulty doing strenuous (great effort) exercise?  | Yes | No |
| 3. Do you have a medical notice from your physician to <b>NOT</b> to participate in long distance runs, such as a 1-mile-run?   | Yes | No |
| 4. Do you have a medical notice from your physician that you are <b>NOT</b> to do curl-ups or push-ups?   | Yes | No |
| 5. Do you exercise less than three times per week for at least thirty minutes?  | Yes | No |
| 6. Have you had any broken bones, a serious accident, or <u>any type of surgery</u> in the last six months?   | Yes | No |
| 7. Do you use tobacco of any kind?  | Yes | No |
| 8. Have you experienced chest, neck, jaw or arm discomfort while doing physical activity?   | Yes | No |
| 9. Do you have difficulty breathing or have sudden breathing problems at night?   | Yes | No |
| 10. Has Asthma ever been documented in any of your medical records growing up?  | Yes | No |
| 11. Do you currently have Asthma?   | Yes | No |
| 12. Are you using an inhaler to aid in breathing?   | Yes | No |
| 13. Do you experience any shortness of breath with relatively low levels of exercise or exertion?   | Yes | No |
| 14. Have you felt any chest pain at rest?   | Yes | No |
| 15. Do your medical records contain any known cardiac (heart) disease?  | Yes | No |
| 16. According to the Navy's height/weight table published on line at: <a href="https://www.navycs.com/navyheightweightchart.html">https://www.navycs.com/navyheightweightchart.html</a> are you overweight? | Yes | No |
| 17. Has your physicians limited any activity due to dizzy/fainting spells, frequent headaches, or frequent back pains?  | Yes | No |
| 18. Have you ever experienced dehydration after strenuous physical exercise that has resulted in your physician now recommending or limiting certain physical activities?                                   | Yes | No |
| 19. Are you currently under treatment by a physician or other medical practitioner?   | Yes | No |
| 20. Has your mother or sister died without any explanation or suffered a heart attack before the age of 55?   | Yes | No |
| 21. Has your father or brother died without any explanation or suffered a heart attack before the age of 45?  | Yes | No |

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|---|------------|-----------|
| 22. Do you have high blood pressure or are you on blood pressure medication?  | <b>Yes</b> | <b>No</b> |
| 23. Has a doctor ever told you that you have high cholesterol or are you on cholesterol medication?   | <b>Yes</b> | <b>No</b> |
| 24. Do you have diabetes?   | <b>Yes</b> | <b>No</b> |
| 25. Have you experienced episodes of rapid beating or fluttering of the heart?  | <b>Yes</b> | <b>No</b> |
| 26. Do you suffer from lower leg swelling of both legs?   | <b>Yes</b> | <b>No</b> |
| 27. Is there any history of metabolic disease (thyroid, renal, liver) listed in any of your medical records?  | <b>Yes</b> | <b>No</b> |
| 28. Do you have a bone, joint, or muscle problem that prevents you from doing strenuous exercises?  | <b>Yes</b> | <b>No</b> |
| 29. Have you unintentionally lost/gained more than 10 percent of your body weight since your last PFA?  | <b>Yes</b> | <b>No</b> |
| 30. Have you ever been diagnosed with Sickle Cell Trait?  | <b>Yes</b> | <b>No</b> |
| 31. Do you have a current prescription for epinephrine (or "epi" pen) for situational use?  | <b>Yes</b> | <b>No</b> |
| 32. Are you currently taking any prescription or non-prescription (over the counter) medications or pills?  | <b>Yes</b> | <b>No</b> |
| 33. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, blisters, pressure sores, or bites) <u>of any kind?</u> | <b>Yes</b> | <b>No</b> |
| If <b>Yes</b> , Please specify: _____   |            |           |
| 34. Have you ever become ill from exercising in the heat?   | <b>Yes</b> | <b>No</b> |

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Cadet Signature/Date	Parent/Guardian Signature/Date
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**PART B – TO BE COMPLETED BY A LICENSED MEDICAL PRACTITIONER**

(If any of the answers to the questions above were **YES**, the following section must be completed and signed by a licensed medical practitioner)

1. List significant clinical history and/or current medication and treatment regimen of the above cadet: (Use below as necessary)

2. Recommended/released for participation in strenuous physical activities including the mile run.

**Yes      No**

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Signature of Medical Practitioner	Date
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