

# NJROTC HEALTH RISK SCREENING QUESTIONNAIRE

Cadet Name: \_\_\_\_\_ (Printed Name)

NJROTC Unit: \_\_\_\_\_ High School

Date of your most recent pre-participation sports physical examination \_\_\_\_\_

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

Directions: Please answer **Yes** or **No** to the following questions: (Do not leave any questions blank)

- |                                                                                                              |                                                          |
|--------------------------------------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. Do you have difficulty doing strenuous (great effort) exercise?                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Have you been told <b>NOT</b> to participate in long distance runs, such as a 1.5-mile-run?               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Have you been told <b>NOT</b> to do curl-ups or push-ups by a physician or other medical professional?    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Do you exercise less than three times per week for at least thirty minutes?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Have you had any broken bones or a serious accident in the last three months?                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Do you use tobacco of any kind?                                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you experienced chest, neck, jaw or arm discomfort while doing physical activity?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Do you have asthma or are you using an inhaler to aid in breathing?                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Do you experience any shortness of breath with relatively low levels of exercise or exertion?             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. In the last month have you felt any chest pain at rest?                                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 11. Do you have any known cardiac (heart) disease?                                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Do you think you are overweight?                                                                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 13. Do you have dizzy/fainting spells, frequent headaches, or frequent back pains?                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 14. Have you ever experienced dehydration after strenuous physical exercise?                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 15. Are you currently under treatment by a physician or other medical practitioner?                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 16. Has your mother or sister died without any explanation or suffered a heart attack before the age of 55?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 17. Has your father or brother died without any explanation or suffered a heart attack before the age of 45? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 18. Do you have high blood pressure or are you on blood pressure medication?                                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 19. Has a doctor ever told you that you have high cholesterol or are you on cholesterol medication?          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 20. Do you have sugar diabetes?                                                                              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 21. Have you experienced episodes of rapid beating or fluttering of the heart?                               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 22. Do you suffer from lower leg swelling of both legs?                                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 23. Do you have difficulty breathing or have sudden breathing problems at night?                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 24. Do you have any personal history of metabolic disease (thyroid, renal, liver)?                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 25. Do you have a bone, joint, or muscle problem that prevents you from doing strenuous exercises?           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 26. Have you unintentionally lost/gained more than 10 percent of your body weight since your last PFT?       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 27. Have you ever been diagnosed with Sick Cell Trait?                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |

\_\_\_\_\_  
Cadet Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**Part B** - If any of the answers to the questions above were **YES**, request that the following section be completed and signed by a licensed medical doctor or registered school nurse:

Significant clinical history and/or current medication and treatment regimen of the above cadet: (Use reverse side if necessary)

Recommended/released for participation in strenuous physical activities including the 1.5-mile-run?  Yes  No

\_\_\_\_\_  
Signature of Medical Practitioner

\_\_\_\_\_  
Date