

ATHLETIC SCREENING EXAM



How are you doing in school? Do you have any questions or concerns?

State law permits adolescents to receive confidential care for certain types of medical conditions.

School: _____ Grade: _____

What sports do you play? _____ Date: _____

Health History

- 1. Do you have any chronic or recurring illness (one that keeps coming back)? Yes No
- 2. Have you had any illness that lasted longer than one week? Yes No
- 3. Have you ever been hospitalized? Yes No
- 4. Have you ever had surgery (other than having your tonsils out)? Yes No
- 5. Do you have any missing organs (eye, kidney, testicle)? Yes No
- 6. Do you have any allergies to medicine, insect bites, or foods?
If yes, please list here: _____ Yes No
- 7. Have you ever had any problems with your heart or blood pressure? Yes No
- 8. Have you ever had chest pain or trouble breathing during exercise? Yes No
- 9. Have you ever felt dizzy or fainted during exercise? Yes No
- 10. Have you ever fainted, had bad headaches, or seizures (convulsions)? Yes No
- 11. Have you ever had a concussion or lost consciousness? Yes No
- 12. Have you ever had heatstroke or heat exhaustion? Yes No
- 13. Do you wear glasses or contacts? Yes No
- 14. Do you have dental bridges, braces, or plates in your mouth? Yes No
- 15. Do you take any medications?
If yes, please list here: _____ Yes No
- 16. Have you ever had an injury that required a doctor's treatment? Yes No
- 17. Have you ever injured your neck or back? Yes No
- 18. Have you ever injured your knee? Yes No
- 19. Have you ever injured your shoulder or elbow? Yes No
- 20. Have you ever injured your ankle? Yes No
- 21. Have you ever had any other serious joint injury? Yes No
- 22. Have you ever broken a bone? Yes No
- 23. Is there any reason you know of why you should not participate in sports? Yes No
- 24. Have any of your close family members died suddenly when they were under age 40, from something other than an accident? Yes No
- 25. Have any of your close family members had a heart attack when they were under age 55? Yes No

** IMPORTANT—PLEASE TURN OVER **



Private Teen Questions (Fill this side out in private)

Do not photocopy

Important! Please read first...

- This information is personal and private. It will not be shared with anyone unless you are being abused (sexually or physically) or are in danger of hurting yourself or someone else.
- Your doctor or other medical professional is asking these questions to discuss your personal health and safety, not to judge you or your friends.

1. Have you smoked cigarettes or used tobacco in the past 30 days? Yes No
2. Have you had any alcohol (beer, wine, liquor) during the past year? Yes No
3. Have you ever tried drugs (such as marijuana, Ecstasy, cocaine, glue, or meth)? Yes No
4. During the past few weeks, have you **often** felt sad, down, or hopeless? Yes No
5. Have you seriously thought about killing yourself, made a plan, or tried to kill yourself? Yes No
- 6a. Have you ever had sex (including oral, vaginal, or anal sex)? Yes No
- 6b. If yes, do you and your partner always use a condom when you have sex? No Yes
7. Do you sometimes have sexual feelings for people of your own sex (gay or lesbian feelings)? Yes No

For young women only

8. Have you started your period? (If no, you are done!) No Yes
9. When was your last period? Write the date it started here: _____
- 10a. My periods are: less than 1 month apart
 every 1 to 2 months
 more than 2 months apart
- 10b. My periods last: less than 8 days
 8 days or longer
11. Do you have cramps that interfere with your daily activities? Yes No
12. Do you need help with managing your cramps? Yes No

Thanks for filling out this questionnaire.