Form Approved
OMB No. 0990-
Exp. Date XX/XX/20XX

Time Point: Enrollment

Eligibility Screener

1. *Date of Birth _____/ _____/ _____
month day year

2. *Which of the following best represents how you think of yourself?
   a. Lesbian or gay
   b. Straight, that is, not lesbian or gay
   c. Bisexual
   d. Something else (go to 2b)
   e. I don't know the answer (go to 2c)

If answered "something else" at initial question:
2b. What do you mean by something else?
   a. You are not straight, but identify with another label such as queer, trisexual, omnisexual or pansexual
   b. You are transgender, transsexual or gender variant
   c. You have not figured out or are in the process of figuring out your sexuality
   d. You do not think of yourself as having sexuality
   e. You do not use labels to identify yourself
   f. You mean something else

If answered "I don't know the answer" to initial question
2c. What do you mean by don't know? *(Show flashcard)*
   a. You don't understand the words
   b. You understand the words, but you have not figured out or are in the process of figuring out your sexuality
   c. You mean something else

What do you mean by something else?_____

Contact Information

CONTACT INFORMATION FORM

Please provide the following contact information. Please print your answers.

First Name _____Middle Name _____ Last Name _____

Current Street Address _____

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_____, _____ _____ _____ _____ _____ _____
City/Town State ZIP CODE

Home Telephone number _____- _____- _____ ⬭ mobile ⬭ landline
Area code

Work Telephone number _____- _____- _____ ⬭ mobile ⬭ landline
Area code

2nd Telephone number _____- _____- _____ ⬭ mobile ⬭ landline
Area code

Check the one to use first

Personal Email address _____ ⬭

Work Email address _____ ⬭

Best time(s) of day and day(s) of the week to contact you

Preferred contact method:

⬭ telephone number _____-_____-_____

⬭ email _____

Do you have a facebook account? ⬭ Yes ⬭ No

↓

Do you have access to internet? Yes ⬭ No ⬭

You are required to obtain medical clearance from your health care doctor to participate in this program. If you do not have a health care doctor at this time, we have a health care provider on staff who can provide medical clearance for you.

Do you have a primary care doctor ? ◯ Yes ◯ No

Name of Doctor _____

Doctor's telephone number_____

Doctor's address_____

The OPAH Fitness Project would like to contact you in a year to schedule an appointment to complete the last piece of evaluation. In order to be sure we can locate you, please give us the names, addresses, and telephone numbers of 2 relatives or friends who would know where you could be reached in case we have trouble reaching you. (Please give us the names of persons not currently living in the household.) All of this information will be kept strictly confidential with the rest of your survey information and will only be used if we cannot get ahold of you.

First Contact Person

First Name _____Middle Name _____ Last Name _____

Current Street Address _____

_____, _____ _____ _____ _____ _____ _____
City/Town State ZIP CODE

Telephone number _____- _____- _____ ◯ mobile ◯ landland
Area code

Alternate Telephone number _____- _____- _____ ◯ mobile ◯ landland
Area code

Email address _____

Relationship to you_____

Second Contact Person

First Name _____Middle Name _____ Last Name _____

Current Street Address _____

_____, _____ _____ _____ _____ _____ _____
City/Town State ZIP CODE

Telephone number _____- _____- _____ ◯ mobile ◯ landland
Area code

Alternate Telephone number _____- _____- _____ ◯ mobile ◯ landland
Area code

Email address _____

Relationship to you_____

Medical History Form

Medical History Form

A. Name_____
First name Last name

B. Date of Birth _____/ _____/ _____
month day year

C. Do you consider yourself to be …

- ◯ Lesbian/gay
- ◯ Bisexual
- ◯ Heterosexual or straight
- ◯ Don't know; Not sure
- ◯ Other (Please specify)_____

D. Currently or in the past, have you identified as transgender or transsexual?

◯ No ◯ Yes

↓

E. What is your assigned birth sex?

- ◯ Male
- ◯ Female

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F. Do you know have any health problem that requires you to use special equipment, such as a cane a wheelchair, a special bed, or a special telephone? **Include occasional use or use in certain circumstances.**

○◯ Yes
○◯ No
○◯ Don't know/ Not Sure

H. *Do you have a lifetime physical or mental impairment that substantially limits one or more major life activities?

◯ Yes ◯ No

I. *If yes, check all that apply:

❒ caring for oneself,
❒ performing manual tasks
❒ walking or standing
❒ lifting or reaching
❒ seeing,
❒ hearing, speaking or communicating
❒ learning, thinking or concentrating
working

Please answer the following questions about your medical history. Circle questions you do not know the answer to.

Medicines and Allergies

1. Please list all of the prescription and over the counter medicines and supplements (herbal and nutritional) that you are currently taking:

---

2. Do you have any allergies?
   No ☐

   Yes ☐ → 2a. What are you allergic to: ☐ Medicines:_____

   ☐Food :_____

   ☐Stinging Insects

3. Have you been told by your physician that you have or have you experienced any of the following?

Condition	Yes	No	Explain "yes" answers

a. Heart Problems	☐	☐	
b. High Blood Pressure	☐	☐	
c. Low Blood Pressure	☐	☐	
d. Diabetes	☐	☐	
e. Hypoglycemia	☐	☐	
f. Asthma	☐	☐	
g. Anemia	☐	☐	
g. High Cholesterol	☐	☐	

4. Have you ever spent the night in the hospital? No__ Yes___ Please list:
   ◌◯ Yes ◯ No

5. Have you ever had surgery? No__ Yes___ Please list:
   ◌◯ Yes ◯ No

YOUR HEART HEALTH

6. Has a doctor ever denied or restricted your participation in physical activity for any reason?
   ◌◯ Yes ◯ No

7. Have you ever passed out or nearly passed out DURING or AFTER exercise?
   ◌◯ Yes ◯ No

8. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?
   ◌◯ Yes ◯ No

9. Does your heart ever race or skip beats (irregular beats) during exercise?
   ◌◯ Yes ◯ No

10. Has a doctor ever told you that you have any heart problems?
    ◌◯ No

    ◌◯ Yes→ check all that apply:

    ☐ A heart murmur

    ☐ A heart infection

    ☐ Kawasaki disease

    ☐ Other:_____

11. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)
◌◯ Yes ◯ No

12. Do you get lightheaded or feel more short of breath than expected during exercise?
◌◯ Yes ◯ No

13. Have you ever had an unexplained seizure?
◌◯ Yes ◯ No

14. Do you get more tired or short of breath more quickly than your friends during exercise?
◌◯ Yes ◯ No

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY (parents, siblings, grandparents)

15. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?
◌◯ Yes ◯ No

16. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?
◌◯ Yes ◯ No

17. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?
◌◯ Yes ◯ No

18. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?
◌◯ Yes ◯ No

BONE AND JOINT QUESTIONS ABOUT YOU

19. Have you ever had any broken or fractured bones or dislocated joints?
◌◯ Yes ◯ No

20. Have you ever had an injury that required xrays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?
◌◯ Yes ◯ No

21. Have you ever had a stress fracture?
◌◯ Yes ◯ No

22. Have you ever been told that you have or have you had an xray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)
◌◯ Yes ◯ No

23. Do you regularly use a brace, orthotics, or other assistive device?
◌◯ Yes ◯ No

24. Do you have a bone, muscle, or joint injury that bothers you?
◌◯ Yes ◯ No

25. Do any of your joints become painful, swollen, feel warm, or look red?
◌◯ Yes ◯ No

26. Do you have any history of juvenile arthritis or connective tissue disease?
◌◯ Yes ◯ No

MEDICAL QUESTIONS

Other Conditions	Yes	No	Explain "yes" answers
27. Do you cough, wheeze, or have difficulty breathing during or after exercise	☐	☐	
28. Have you ever used an inhaler or taken asthma medicine?	☐	☐	
29. Is there anyone in your family who has asthma?	☐	☐	
30. Have you had a herpes or MRSA skin infection?	☐	☐	
31. Have you ever had a head injury or concussion?	☐	☐	
32. Have you ever had a hit or blow to the head that caused confusion, prolonged headaches, or memory problems?	☐	☐	
33. Do you have a history of seizure disorder?	☐	☐	
34. Do you have headaches with exercise?	☐	☐	
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being with walking or other light exercise?	☐	☐	
36. Have you ever become ill while exercising in the heat?	☐	☐	
37. Do you get frequent muscle cramps when exercising?	☐	☐	
38. Do you or someone in your family have sickle cell trait or disease?	☐	☐	
39. Have you had any problems with your eyes or vision?	☐	☐	
40. Have you had any eye injuries?	☐	☐	
41. Do you wear glasses or contact lenses?	☐	☐	
42. Do you wear protective eyewear, such as goggles or a face shield?	☐	☐	

WEIGHT QUESTIONS ABOUT YOU AND YOUR FAMILY

43. Do you worry about your weight?
◌◯ Yes ◯ No

44. Are you trying to or has anyone recommended that you gain or lose weight?
◌◯ Yes ◯ No

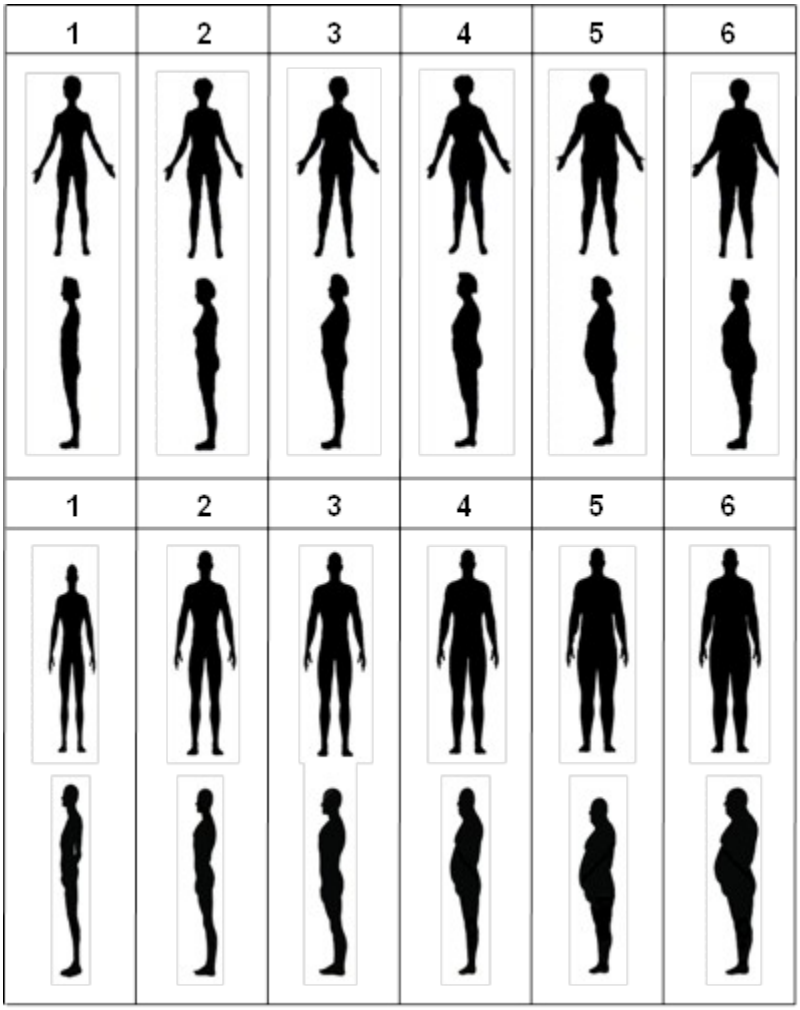
45. Are you on a special diet or do you avoid certain types of foods?
◌◯ Yes ◯ No

46. Have you ever had an eating disorder?

◌◯ Yes, please explain_____

◌◯ No

47. Circle the diagram that best depicts the approximate outline of each of your *natural* parents at 50 years old?



◯ Don't know

◯ Don't know

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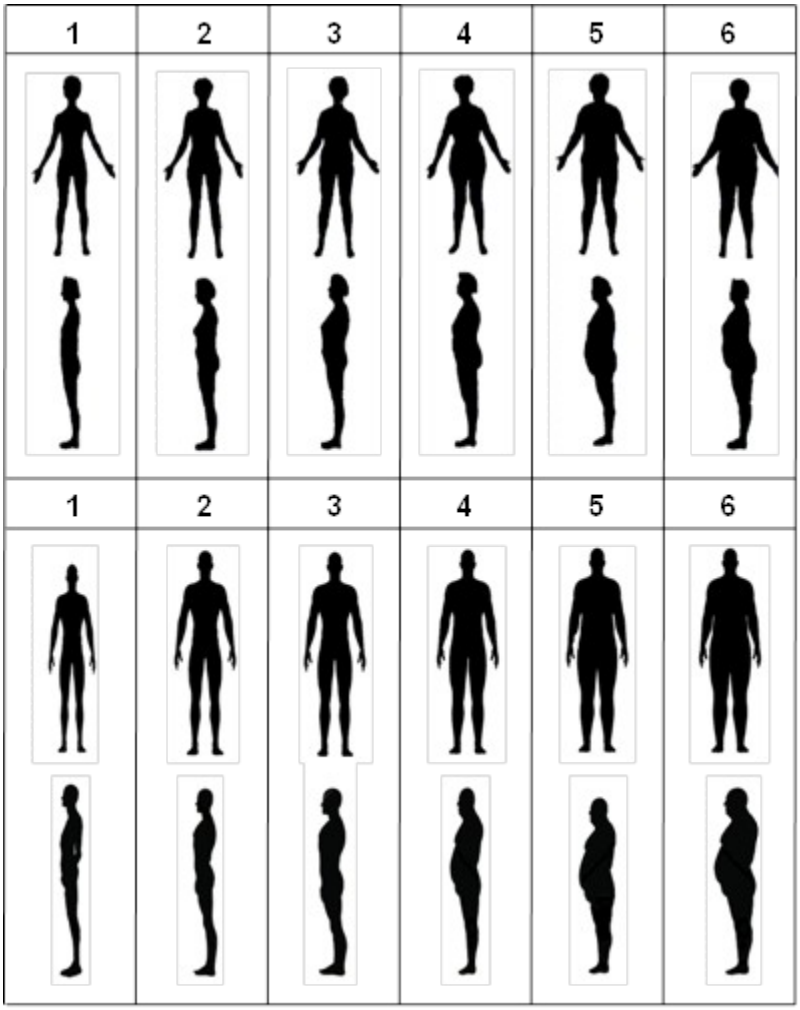
48. Circle the number of the diagram that best depicts the approximate outline of your partner.



◯ Don't know

◯ Do not have a partner

49. **Do you NOW smoke cigarettes every day, some days, or not at all?**

◯ Every day → 47a. What is the age you started_____

◯ Some days → 47b. What is the age you started_____

◯ Not at all

50. **Have you smoked at least 100 cigarettes in your entire life?**

◯ Yes ◯ No (go to Question 53)

51. **On the days you <u>currently</u> smoke, how many cigarettes do you smoke?** _____ cigarettes

52. **Which statement best describes you now…**

○◯ I am trying to quit

○◯ I plan to quit smoking tobacco (within the next month)

○◯ I think about quitting smoking tobacco some time in the future (in the next 6 months)

○◯ I don't think about quitting smoking tobacco

53. **Have you had at least one menstrual period in the past 12 months? (Please do not include bleedings caused by medical conditions, hormone therapy, or surgeries.)**

○◯ Yes ◯ No ◯ N/A

Below is a list of the ways you might have felt or behaved. Mark how often you have felt this way during the past week.

In the past week:	Rarely or none of the time (less than 1 day)	Some of a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the time (5-7 days)
54. I felt depressed				
55. I felt lonely				
56. I had crying spells				
57. I felt sad				

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

Signature of Participant: _____Date:_____

PRE-PARTICIPATION PHYSICAL EVALUATION
EXAMINATION

BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Yes ☐ No

MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance		
Eyes/Ears/Nose/Throat ○◯ Pupils equal ○◯ Hearing		
Heart* ○◯ Murmurs (auscultation standing, supine, +/- Valsalva) ○◯ Location of point of maximal pulse (PMI)		
Pulses		

◌◯ Simultaneous femoral and radial pulses
◌◯ Lungs

Neurologic***

	NORMAL	ABNORMAL FINDINGS
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional		

* Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam
◌◯ Cleared for exercise without restriction.
◌◯ Cleared for exercise without restriction **with recommendations for further evaluation or treatment for**:

I have examined the above-named participant and completed the pre-participation physical evaluation. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the participant has been cleared for participation, the physician may rescind the clearance until the problem is resolved.

Name of Physician (type/print): Date:
Address: Phone:

Signature of Physician (MD/DO/ARNP/PA/Chiropractor*):

Demographics Questionnaire

1. *What is your current employment status?

Working part-time (less than 32 hours/week)
Working full-time (32 or more hours/week)
Unemployed, laid off, on strike
Retired
Disabled or unable to work
In school full time and not working
Full-time homemaker

2. *What is the highest grade of school you have completed or the highest degree you have received?

Less than high school
High school or GED
Technical school -- no degree
Some college -- no degree
2-year college degree/technical school degree
4-year college degree
Post-graduate work or degree

3. *Are you of Hispanic or Latino origin?

Yes
No
Don't know/not sure

4. *Which one or more of the following would you say is your race? Check all that apply.

White
Black or African American
Asian
Native Hawaiian or Other Pacific Islander
American Indian or Alaska Native

5. What is your annual household income from all sources?

≤ $15,000
$15,001 to 30,000
$30,001 to 50,000
$50,001 to 100,000
$100,000 to $150,000
More than 150,001

6. *Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare? (BRFSS 2008)

Yes
No
Don't know/Not sure

7. *How "out" are you about your sexuality with your health care providers (doctors, nurses, nutritionists, mental health professionals, personal trainers, etc.)

Out to all
Out to some
Out to a few
Out to None
N/A

8. *Which of the following best describes your present relationship?

In a committed relationship with a woman (for example, cohabiting, domestic partnership, or legally married)
In a committed relationship with a man (for example, cohabiting, domestic partnership, or legally married)
Single, but somewhat involved with a woman, man, or both
Single, and not involved with anyone

9. *If in a committed relationship, do you currently live with your partner …

All or most of the time
Some of the time
None of the time
I do not have a partner

10. Are you a parent?

Yes
No

11. Do you have any of the following responsibilities?

(Please check all that apply)

Infants, toddlers, or pre-school age children who live with you at least half the year
Elementary, middle, or high school age children who live with you at least half the year
Children 18 or over who live with you at least half the year
Children away at college for whom you are financially responsible
A disabled or ill member of your household
Elders for whom you are providing ongoing care for more than 3 hours a week
Member of the community (not an elder) for whom you are providing ongoing care for more than 3 hours a week
None of the above

12. Do you have a dog in the household that is regularly walked?

Yes
No