Form Approved

OMB No. 0920-xxxx

Exp. Date xx/xx/20xx

POLICE HEALTH STUDY

ELIGIBILITY SCREENING FORM

**1. Are you CURRENTLY taking any of the following medications?**

*(Please mark an “X” in the appropriate box and if medication is taken, answer the questions on*

 *dosage and duration.)*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **No**(0) | **Yes**(1) | **Pill Size or Dose** | **Number of pills or dose you take per day or week** | **Duration of use (dates)** |
| 1 | ***Dexamethasone*** |  |  |  |  |  |
| 2 | Anabolic steroids (testosterone)  |  |  |  |  |  |
| 3 | Prednisone or cortisone |  |  |  |  |  |
| 4 | Phenytoin |  |  |  |  |  |
| 5 | Phenobarbital |  |  |  |  |  |
| 6 | Ephedrine |  |  |  |  |  |
| 7 | Indomethacin |  |  |  |  |  |
| 8 | Rifampin |  |  |  |  |  |

2. Are you ALLERGIC or have you REACTED ADVERSELY to the following?

 *(Please mark an “X” in the appropriate box.)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **No**(0) | **Yes**(1) | **Don’t know or never taken**(3) |
| 1 | Any steroid drugs |  |  |  |
| 2 | ***Dexamethasone*** |  |  |  |
| 3 | Localanesthetics |  |  |  |
| 4 | Antibiotics - Penicillin |  |  |  |
| 5 | Food allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| 6 | OtherSpecify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

Public reporting burden of this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

**3. Are you pregnant? (Women only)**

 □ (0) No □ (1) Yes

**4. Are you breast-feeding? (Women only)**

 □ (0) No □ (1) Yes

**5. Are you lactose intolerant or do you have allergies to dairy products?**

 □ (0) No □ (1) Yes

**6. Do you have kidney or renal problems?**

 □ (0) No □ (1) Yes

 **If YES, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**7. Within the past 30 days have you had any tests that used contrast agents or dyes?**

 □ (0) No □ (1) Yes

 **If YES, date of test \_\_ \_\_/\_\_ \_\_/\_\_ \_\_ \_\_ \_\_**

**8. Do you CURRENTLY have or are you being treated by a physician for any of the following?**

*(Please check all that apply.)*

|  |  | **No**(0) | **Yes**(1) |
| --- | --- | --- | --- |
| 1 | Blood clotting problems |  |  |
| 2 | Hypertension / high blood pressure |  |  |
| 3 | Peptic or other ulcer |  |  |
| 4 | Osteoporosis |  |  |
| 5 | Diabetes mellitus |  |  |
| 6 | Glucose intolerance or high blood sugar |  |  |
| 7 | Tuberculosis |  |  |
| 8 | Fungal infection in the bloodstream (NOT athlete’s foot) |  |  |
| 9 | Herpes |  |  |
| 10 | Mononucleosis |  |  |
| 11 | Venereal disease or sexually transmitted disease |  |  |
| 12 | Other infection, Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 13 | Arteriosclerosis |  |  |
| 14 | Stroke |  |  |
| 15 | Heart attack |  |  |
| 16 | Heart disease |  |  |
| 17 | Rheumatic fever or rheumatic heart disease |  |  |
| 18 | Congenital heart lesions |  |  |
| 19 | Heart murmur |  |  |
| 20 | Mitral valve prolapse |  |  |
| 21 | Anemia or other blood disorder |  |  |
| 22 | Pituitary gland problem |  |  |
| 23 | Neurological condition, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| 24 | Other disease, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

 ID Number \_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Maiden Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone # (for clarification)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Best time to contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GENDER\_\_\_\_\_\_\_\_\_\_

Please fill in your assigned appointment date and time.

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information is being used for prescreening purposes and will be kept confidential.