

## 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	<b>Dexamethasone</b>					
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	<b>Dexamethasone</b>			
3	Local anesthetics			
4	Antibiotics - Penicillin			
5	Food allergies _____			
6	Other Specify _____			

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.)*

		<b>No</b> (0)	<b>Yes</b> (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		

		<b>No</b> (0)	<b>Yes</b> (1)
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.