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	Local anesthetics			
4	Antibiotics - Penicillin			
5	Food allergies _____			
6	Other Specify_____			

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 <u>CURRENTLY</u> 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		

		No (0)	**Yes** (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.