HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE:	NAVAL HEALTH CLINIC QUANTICO (DAVID R. RAY BHC)
	3259 CATLIN AVE, QUANTICO, VA 22134

TRAINING PRE-PARTICIPATION SCREENING

Questions	**Circle** Yes OR No	**COMMENTS** (Place question number and explain in as much detail as possible for all yes answers)
1. Is there any reason that you cannot perform physical activity?	YES/NO	
2. Do you currently have any physical limitations?	YES/NO	
3. Have you been treated by any type of medical provider OR has their been any changes in your medical history or status since your last military physical, PHA, or certification?	YES/NO	
4. Have you EVER had any heart, circulation, hypertension, or eholesterol problems?	YES/NO	
5. Have you EVER had diffiiculty breathing, chest pain, light headedness, dizziness, passed out, or nearly passed	YES/NO	
6. Have you EVER had frequent severe headaches?	YES/NO	
7. Do you suffer from lactose intolerance?	YES/NO	
8. Has anyone in your immediate family died from a heart condition, suddenly before age 50, or diagnosed with Marfan's syndrome?	YES/NO	
9. History of heat stroke, heat exhaustion, or cold weather injuries (i.e. hypothermia, frostbite)?	YES/NO	
10. History of concussion or other head or neck injury?	YES/NO	
11. Have you EVER had any fractures, stress fractures, sprains, strains, ligament, tendon, or other muscle injuries?	YES/NO	
12. Have you EVER had surgery of any kind? (Including arthrospcopy or minimally invasive)	YES/NO	
13. Have you EVER had any subluxation or dislocations of your shoulders or any other joint?	YES/NO	
14. Have you EVER had any back or neck pain or injury?	YES/NO	
15. Have you EVER had any shin splints, shin pain, leg pain, or achilles pain?	YES/NO	
16. Have you EVER seen an Orthopedist or Podiatrist?	YES/NO	
17. Have you EVER experienced any pain or been treated for injuries not listed?	YES/NO	
18. Have you tested positive for Covid- 19 in the last SIX months? If yes, fill out additional Covid- 19 questionnaire.	YES/NO	**All information is correct to the best of my knowledge.**
19. Have you ever been disqualified or been dropped from participating in sports or military training of any kind?	YES/NO	**Patient Signature:** _____

For MSK Provider (if examined): **Member has been found** PHYSICALLY QUALIFIED / NOT PHYSICALLY QUALIFIED / DECISION PENDING DIAGNOSTICS **EVALUATED BY:**	**PATIENT'S NAME(Last, First, MI)**		**SEX** MALE OR FEMALE
	RELATIONSHIP TO SPONSOR	**STATUS** ACTIVE	**RANK/GRADE**
	SPONSOR'S NAME SELF		**COMPANY/PLATOON**
	DEPT/SERVICE DOD/USMC	**DODID**	**DOB(YYYYMMDD)**