**Body Composition**

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>BMI (20 years of age and over)</th>
<th>BMI Percentile (under 20 years of age)</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ cm</td>
<td>_____ kg</td>
<td>______</td>
<td>______</td>
</tr>
</tbody>
</table>

**Bone Mineral Density Test (Athletes MUST be at least 20 years old to screen)**

<table>
<thead>
<tr>
<th>T-score</th>
<th>Left heel</th>
<th>Right heel</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.0 to +5.0</td>
<td>_____</td>
<td>_____</td>
</tr>
</tbody>
</table>

- □ Unable to test
- □ Age under 20
- □ Athlete refused
- □ Athlete unable to cooperate
- □ Unusual heel shape

**Blood Pressure**

<table>
<thead>
<tr>
<th>Right arm</th>
<th>Left arm</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong><strong>/</strong></strong></td>
<td><strong><strong>/</strong></strong></td>
</tr>
</tbody>
</table>

**Nutrition – Food and Beverage Habits**

**What do you usually drink when you are thirsty**? (select all that apply)

- □ Water
- □ Fruit juice
- □ Soft drink
- □ Milk product (includes soy)
- □ Energy drink
- □ Other

**Sources of Calcium**

<table>
<thead>
<tr>
<th>O less than 1 serving per day</th>
<th>O 1-2 servings per day</th>
<th>O 3-5 servings per day</th>
<th>O more than 5 servings per day</th>
<th>O never</th>
</tr>
</thead>
</table>

**Sweetened Beverages**

<table>
<thead>
<tr>
<th>O daily</th>
<th>O weekly</th>
<th>O monthly</th>
<th>O never</th>
</tr>
</thead>
</table>

**Fruits and Vegetables**

<table>
<thead>
<tr>
<th>O less than 1 serving per day</th>
<th>O 1-2 servings per day</th>
<th>O 3-5 servings per day</th>
<th>O more than 5 servings per day</th>
<th>O never</th>
</tr>
</thead>
</table>

**Snack Foods**

<table>
<thead>
<tr>
<th>O daily</th>
<th>O weekly</th>
<th>O monthly</th>
<th>O never</th>
</tr>
</thead>
</table>

**Fast food**

<table>
<thead>
<tr>
<th>O daily</th>
<th>O weekly</th>
<th>O monthly</th>
<th>O never</th>
</tr>
</thead>
</table>
### Physical Activity

**How many days per week do you exercise for at least 30 minutes?**
- [ ] No days
- [ ] 1-2 days
- [ ] 3-6 days
- [ ] Every day

**Do you exercise outside of your Special Olympics training?**
- [ ] Yes
- [ ] No

*If yes, what do you do? (select all that apply)*
- [ ] Weight training
- [ ] Run/Jog
- [ ] Walk
- [ ] Dance
- [ ] Sports
- [ ] Exercise video
- [ ] Other

**If No, what is the reason? (select all that apply)**
- [ ] No interest
- [ ] No money
- [ ] Do not know how
- [ ] Physically unable
- [ ] No transportation
- [ ] No one to do it with
- [ ] No available exercise facility
- [ ] No time
- [ ] Other

**How many hours a day do you watch television or play computer/video games?**
- [ ] 0-2
- [ ] 3-4
- [ ] 5-6
- [ ] Over 6 hours

### Hand Washing

**When are the most important times to wash your hands? (select all that apply)**
- [ ] After using the toilet
- [ ] Other reason
- [ ] Before eating or touching food
- [ ] No response/no reasons given

**Did you use soap last time you washed your hands?**
- [ ] Yes
- [ ] No

**Do you have soap at your home?**
- [ ] Yes
- [ ] No

### Sun Safety

**Do you do anything to protect your skin in the sun?**
- [ ] Yes
- [ ] No

*If yes, what do you do to protect your skin in the sun? (select all that apply)*
- [ ] Use sunscreen
- [ ] Wear a hat
- [ ] Seek shade
- [ ] Wear sunglasses
- [ ] Wear long sleeves
- [ ] I do not do anything

*If no, what is the reason? (select all that apply)*
- [ ] Did not know it was important
- [ ] No money to buy protection
- [ ] Do not get sunburned
- [ ] Like to be tan
- [ ] Other

### Tobacco Use

**Do you use tobacco?**
- [ ] Yes
- [ ] No

*If yes, how frequently?*
- [ ] Daily
- [ ] Weekly
- [ ] Monthly

**Do any of your friends or family members smoke near you?**
- [ ] Yes
- [ ] No

*If yes, what do you do when they are smoking near you? (select all that apply)*
- [ ] Ask them to stop
- [ ] Leave the room
- [ ] Smoke
- [ ] I do not do anything
- [ ] Other