Physical Training
Pre-Participation Screening Questionnaire

1. Name_________________________________Office Symbol_________
2. Work Phone:____________ Email Address: _______________________
3. Sex (circle one): MALE FEMALE Age_____
4. Person to Contact in Case of Emergency:
   Name___________________Relationship__________Phone__________
5. Are you taking any medications or drugs? YES NO
   If yes, please list drugs (incl. supplements)________________________
   Why do you take the drug?_______________________________________

Before engaging in a moderate physical conditioning program, certain medical or health issues need to be addressed. This is especially important if you are over 40. Occasionally, diseases are present which the individual is unaware. This is often true in the beginning stages of cardiovascular (heart and blood vessel) disease — especially as an individual gets older. These undetected or "sub-clinical" diseases may cause problems when a vigorous exercise program is begun.

Part I: Assess your health needs by marking all *true* statements

HISTORY

You have had:

- ❑ a heart attack
- ❑ heart surgery
- ❑ cardiac catheterization
- ❑ coronary angioplasty (PTCA)
- ❑ pacemaker/implantable cardiac defibrillator/rhythm disturbance
- ❑ heart valve disease
- ❑ heart failure
- ❑ heart transplantation
- ❑ congenital heart disease

- ❑ You experience chest discomfort with exertion
- ❑ You experience unreasonable breathlessness
- ❑ You experience dizziness, fainting, blackouts
- ❑ You take heart medications

Other Health Issues

- ❑ You have musculoskeletal problems
- ❑ You have concerns about the safety of exercise
- ❑ You are pregnant
- ❑ You take or have taken prescription medication for asthma, high blood pressure, or high Cholesterol

Part II: Assess your cardiovascular risk by marking all *true* statements

Cardiovascular Risk Factors

- ❑ You are a man older than 45 years
- ❑ You are a woman older than 55 years or you have had a hysterectomy or you are post menopausal
- ❑ You smoke
- ❑ Your blood pressure is greater than 140/90
- ❑ You don't know your blood pressure
- ❑ Your blood cholesterol level is >240 mg/dL

- ❑ **You don't know your cholesterol level**
- ❑ **You have a close blood relative who had a heart attack before age 55 (father or brother) or age 65 (mother or sister)**
- ❑ **You are diabetic or take medicine to control your blood sugar**
- ❑ **You are physically inactive (i.e., you get less than 30 minutes of physical activity on at least 3 days**
- ❑ **You are more than 20 pounds overweight**

These medical questions are not designed to detect unfit individuals, but to identify and treat potential medical problems before they occur. The small number of problems that are identified are usually referred for further testing and, in many cases, a specifically designed exercise program is offered to provide good fitness training while preventing further complications.

Participant's Signature___________________________________Date________________

Part III: This section must be signed by your supervisor

HEALTH CARE PROVIDER REFERRAL

Your patient, ____, desires to participate in the Physical Activity Program offered by the Air Force. This program permits civilian employees the opportunity to participate in frequent, regular and/or routine physical activities, which supports a healthy working environment. Clearance from you prior to participation in the Civilian Physical Fitness Program is required. Please complete the attached Health Care Provider Approval Form and return it to the patient listed above.

Supervisor's Signature _____________________________________Date_________________

Part IV: **This section may be signed by a Physician, Physician's Assistant, or Nurse Practitioner**

HEALTH CARE PROVIDER APPROVAL

Patient name ____

(print)

has medical approval to participate in the Air Force Civilian Physical Fitness Program. I understand that the program could include mild to moderate intensity exercise, and may be conducted in unsupervised groups or individually. I also understand that participation is voluntary, allowing the participant to stop and rest at any time he or she desires.

The following restrictions apply (if none, so state):

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Health Care Provider's Name____

Office telephone number____

Email address __________________________

Health Care Provider's Signature__________________________ **Date**_____________