

Air Force Physical Fitness Screening Questionnaire (FSQ)

Privacy Statement

AUTHORITY: Title 10 United States Code 9013, Secretary of the Air Force; AFI 36-2905, *Physical Fitness Program*.

PRIMARY PURPOSE: You are being asked these questions for your safety and health. The Fitness Assessment is a maximum effort test. Airmen who have not been exercising regularly and/or have underlying medical risk factors (as screened below) are at increased risk of injury or death during a fitness assessment. *Answering these questions honestly is in your best interest.*

ROUTINE USES: Disclosures are permitted under Title 5 United States Code 552a(b), Privacy Act of 1974, as amended.

DISCLOSURE: Mandatory use by Regular Air Force, Reserve and Guard members.

PART I. MEMBER COMPLETES

NAME:	RANK:	OFFICE SYMBOL:	DUTY PHONE:
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1. Have you experienced any of the symptoms/problems listed below and not been medically evaluated and cleared for unrestricted participation in a physical training program?

- a. Unexplained chest discomfort with or without exertion
- b. Unusual or unexplained shortness of breath
- c. Dizziness, fainting, or blackouts associated with exertion
- d. Unpleasant feelings of rapid, irregular, or forceful heartbeats
- e. Unusual leg pain, cramping, or weakness during exercise
- f. Family history of sudden death before age of 40 in a first degree relative (e.g., biological mother, father, sibling, or child)
- g. Other medical conditions (e.g., diabetes, kidney disease, heart disease, a history of rhabdomyolysis, heat stroke, new medications, etc.) or surgical considerations that may prevent you from safely participating in a fitness assessment and have not been addressed with adequate restrictions on an AF Form 469, *Duty Limiting Condition Report*

Have you answered "Yes" to ANY of the above conditions?

☐ **Yes: Stop.** Notify your unit fitness program manager (UFPM) (to address rescheduling, etc.) and contact your primary care provider (PCP) for evaluation/recommendations (for Air Reserve Component, contact the medical liaison officer (MLO) for duty limiting conditions documentation and referral to PCP). Hand carry this form to your PCP or MLO.

☐ **No:** Proceed to next question.

2. Do you know your sickle cell trait (SCT) screening test status? If unknown, you may access <https://imr.afms.mil/imr/myIMR.aspx>. (Note: this system is not your official medical record, but it contains readiness data.)

☐ **Yes:** Proceed to question 3. If your SCT screening was negative, answer "Yes" to question 3.

☐ **No: Stop.** Notify your UFPM that you are not cleared for a fitness assessment. Complete the remainder of your questionnaire and hand carry this form to your medical provider for evaluation.

3. If you have SCT, you are directed to complete two (2) counseling sessions regarding SCT with a health care provider at some time in your career AND watch the educational video about SCT once a year (<https://www.hprc-online.org/articles/sickle-cell-trait-awareness> OR <https://www.youtube.com/watch?v=8s9nKcFd-Fk>). Based on your SCT screening test result, have you completed the necessary counseling and education?

☐ **Yes:** I completed training OR my SCT screening test was negative. Proceed to question 4.

☐ **No: Stop.** Notify your UFPM that you are not cleared for a fitness assessment. Complete the remainder of your questionnaire and hand carry this form to your medical provider for evaluation.

4. Have you engaged in vigorous physical activity (i.e., activity causing sweating and moderate to severe increase in breathing and heart rate) averaging at least 30 minutes per session, 3 days per week, over the last 3 months?

☐ **Yes: Stop.** Sign form and return to your UFPM. Airman may take the fitness assessment.

☐ **No:** Proceed to the next question.

(OVER)

Air Force Physical Fitness Screening Questionnaire (FSQ) Continued

5. Do one (1) or more of the following risk factors apply to you? Note: this question only applies if you answered "No" to question 4.

- a. Smoked tobacco products in the last 30 days
- b. Diabetes
- c. High blood pressure **OR** high cholesterol that is not controlled
- d. Family history of heart disease (developed in father/brother before age 55 or mother/sister before age 65)
- e. Age > 45 years for males; > 55 years for females

Have you answered "Yes" to ANY of the above conditions in block 5?

- ☐ **Yes: Stop.** Notify your UFPD that you are not cleared for a fitness assessment. Complete the remainder of your questionnaire and hand carry this form to your medical provider for evaluation.
- ☐ **No: Stop.** Sign form and return to your UFPD. Airman may take the fitness assessment if they were not disqualified by questions 1 through 4.

By signing below, I affirm that this questionnaire was filled out truthfully. Further, I acknowledge that if I recognize any of the following warning signs I should stop my fitness assessment immediately and seek medical attention:

- a. Unexplained chest pain
- b. Shortness of breath
- c. Dizziness
- e. Blurry vision
- f. Unusual leg pain, cramping, and or weakness

DATE:

SIGNATURE:

PART II. MEDICAL PROVIDER COMPLETES

If medical evaluation is required in accordance with this FSQ, the provider will complete the following.

I medically evaluated _____ on _____.
(RANK, NAME) (DATE)

Medical recommendations are:

- Member (is / is not) medically cleared for best effort on the maximal effort 1.5-mile run.
- Member (is / is not) medically cleared for best effort on the sub-maximal effort 2.0-km walk.
- Member (is / is not) medically cleared for push-ups.
- Member (is / is not) medically cleared for sit-ups.

NOTE: An AF Form 469 has been initiated if appropriate. Airmen with fitness limitations greater than 30 days should be given an exercise prescription in accordance with AFI 36-2905.

(SIGNATURE/STAMP OF PROVIDER)