Air Force Physical Fitness Screening Questionnaire (FSQ)

Privacy Statement

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

PRIMARY PURPOSE: You are being asked these questions for your safety and health. The AF Fitness Assessment (FA) 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 the test. 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.

Name:	**Rank:**	**Office Symbol:**	**Duty Phone:**

1A. Do you have a profile or an exemption?

Yes: Provide a copy to fitness administrator, once complete, proceed to next question

No: Proceed to next question

1B. 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. Fever or flu-like symptoms
f. Unusual leg pain, cramping, or weakness during exercise
g. Family history of sudden death before age of 40 in a first degree relative (e.g., biological mother, father, sibling, or child)
h. Other medical conditions (e.g., COVID-19, 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 this test and have not been addressed with adequate restrictions on the AF Form 469

1C. Have you answered "Yes" to ANY of the above conditions?

☐ **Yes: Stop.** Notify your UFPM (to address rescheduling, etc.) and contact your Primary Care Provider (PCP) for evaluation/ recommendations (or for ARC, contact the MLO for Duty Limiting Conditions (DLC) documentation and referral to PCP. Hand carry this form to medical evaluation.

☐ **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 your fitness test. Complete the remainder of your questionnaire and hand carry this form to medical 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 your fitness test. Complete the remainder of your questionnaire and hand carry this form to medical 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.

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
f. Diagnosed previously with COVID-19 AND have NOT been cleared for physical activity by a healthcare provider

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

☐ **Yes: Stop.** Notify your UFPM that you are not cleared for your fitness test. Complete the remainder of your questionnaire and hand carry this form to medical evaluation.

☐ **No: Stop.** Sign form and return to your UFPM. Airman may take the FA if they were not disqualified by question 1-4.

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 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:**

CONTROLLED UNCLASSIFIED INFORMATION PRIVACY SENSITIVE

To Be Completed By Medical

If medical evaluation is required IAW this FSQ, the provider will complete the following.

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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 AFMAN 36 2905.

_____
(SIGNATURE/STAMP OF PROVIDER)