

## FITNESS SCREENING QUESTIONNAIRE

*The proponent agency is ANG/SG. The prescribing directive is ANGI 10-248.*

### PRIVACY ACT STATEMENT

**AUTHORITY:** Title 10 USC 8013, and Executive Order 9397.

**PURPOSE:** To process members into and through the Air National Guard Fitness Program. SSN is collected to identify the ANG Member in the ANG Fitness Program database.

**ROUTINE USES:** None.

**DISCLOSURE:** Mandatory; Failure to provide this information may result in administrative actions.

TODAY'S DATE:	NAME:	SSN:
RANK:	<input type="checkbox"/> TITLE 32 - AGR <input type="checkbox"/> TRADITIONAL <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH:
AFSC:	ASSIGNED UNIT:	WING:

EMAIL: *(Please use an address that you check frequently. Can be non-military.)*

### DO I QUALIFY FOR THE 1.5 MILE RUN?

IF YOU ANSWER YES TO ANY OF THESE QUESTIONS, YOUR PRIVATE HEALTHCARE PROVIDER MUST PROVIDE DOCUMENTATION STATING YOU ARE CLEARED TO RUN. You are to present a dated and signed Memorandum for Medical Clearance to the Fitness Program Medical Liason (FPML) at the Medical Group. Once cleared by the FPML a copy needs to go with the individual member and delivered to the UFPM. The UFPM will keep on file with the Fitness Assessment.

\_\_\_\_\_ INITIALS

**YES    NO**

- DO YOU HAVE A FAMILY HISTORY OF HEART DISEASE? (Father/Brother before age 55, mother/sister before age 65, or children)
- DO YOU HAVE HIGH BLOOD PRESSURE?
- DO YOU HAVE CHOLESTEROL OVER 200? (Documented within the last 12 months) OR DO YOU NOT KNOW YOUR CHOLESTEROL?
- ARE YOU A MALE WITH A WAIST MEASUREMENT OVER 40"?
- ARE YOU A FEMALE WITH A WAIST MEASUREMENT OVER 35"?
- HAVE YOU SMOKED CIGARETTES IN THE LAST 30 DAYS?
- I HAVE NOT RUN FREQUENTLY DURING THE PAST 3 MONTHS (Not run vigorously for 30 minutes, at least 3 times per week)

### PHYSICAL ACTIVITY READINESS QUESTIONS

IF YOU ANSWER YES TO ANY OF THESE QUESTIONS, PLEASE NOTIFY THE UNIT FITNESS PROGRAM MANAGER BEFORE THE ASSESSMENT BEGINS. (If you completed these questions prior to today, please ensure that your answers are still correct.) \_\_\_\_\_ INITIALS

**YES    NO**

- HAVE YOU EVER BEEN DIAGNOSED WITH A HEART CONDITION?
- DO YOU HAVE CHEST PAIN BROUGHT ON BY PHYSICAL ACTIVITY?
- DO YOU FEEL LIGHT-HEADED OR DIZZY WHEN EXERCISING?
- DO YOU HAVE ANY BONE OR JOINT PROBLEMS OR INJURIES?
- ARE YOU TAKING ANY PRESCRIBED MEDICATIONS THAT COULD AFFECT YOU DURING EXERCISE? (Women: Excludes birth control)
- ARE YOU PREGNANT OR NURSING? (Women Only)
- ARE YOU AWARE OF ANY REASON AGAINST EXERCISING WITHOUT MEDICAL SUPERVISION?

### HEALTHY HABIT QUESTIONS

**YES    NO**

- DO YOU SMOKE OR USE TOBACCO?
- ARE YOU A MEMBER OF A HEALTH CLUB?
- \_\_\_\_\_ 0    HOW MANY TIMES DO YOU EXERCISE IN A TYPICAL WEEK?

MEMBER'S SIGNATURE:

DATE: