FS-5100-31 (v. 3/2016)
OMB No. 0596-00164

HEALTH SCREENING QUESTIONNAIRE

Name:____ Date:_____________________________

Level of test: _____ Light _____ Moderate _____ Arduous

Assess your health needs by marking all true statements.

The purpose of the HSQ is to identify individuals who may be at risk while taking the Work Capacity Test (WCT) and recommend an exercise program and/or medical examination prior to taking the WCT.

Employees are required to answer the following questions which were designed to identify those individuals who may be at medical risk when taking the WCT. This is not a medical exam. Any medical concerns you have that may put you or your health at risk should be reviewed with your personal physician prior to participating in the WCT.

SECTION A

You have/had:

____ a heart attack
____ heart surgery
____ coronary (heart) angioplasty or stent placement
____ a pacemaker/implantable cardiac defibrillator/rhythm disturbance (abnormal heartbeat)
____ heart valve disease or a heart murmur
____ heart failure
____ heart transplantation
____ congenital (born with) heart disease
____ personal experience or a doctor's advice of any other physical reason that would prohibit you from carrying out or participating in strenuous activity

You experience:

____ chest discomfort/pain with exertion
____ breathlessness more than others with exertion
____ dizziness, fainting, blackouts
____ muscle or bone/joint problems: spine, knees, back, hips, shoulders, etc. (swelling, moderate pain)

Other Health Issues:

____ you have a hernia
____ you take heart or asthma medications
____ you have epilepsy or a seizure disorder
____ you have a history of past heat that would exhaustion/stroke that required medical care
____ I have a waiver for ________________

SECTION B

Cardiovascular risks:

____ you are physically inactive (i.e. you get less than 30 minutes of physical activity less than 3 days per week)

____ you smoke currently or in the past 6 months

____ your blood pressure is greater than 139/89, or you take blood pressure medication

____ you don't know your blood pressure

____ you have a body mass index (BMI) ≥ 30*

____ your blood cholesterol level is greater than 200 mg/dL, or your HDL is less than 40 mg/dL, or you take cholesterol medication

____ you don't know your cholesterol level

____ you are diabetic: diet controlled or you take medicine to control your blood sugar

*To determine go to: http://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm

I understand that if I need to be evaluated by a physician, it will be based on the fitness requirements of the position(s) for which I am qualified.

I have read and understand the above and answered truthfully.

Signature____ Date ___________________________

Printed Name ____

Unit:____ HSQ Coordinator:_____________________

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