

Pre- and Post-Test Session Participant Questionnaire and Examination

***To be completed by the Test Participant ***

Please complete the form below. If you do not understand a question or word, please ask.

Name: _____ Date: _____

Emergency Point of Contact: _____ Phone Number: _____

- 1 Do you feel sick today? Yes No
- 2 Have you had a cold, flu, or illness within the last two weeks? (if no, skip to question 4) Yes No
- 3 How long has it been since you recovered from the cold, flu, or illness (number of days)? Yes No
- 4 _____
Have you used tobacco products within the last 12 hours? Yes No
- 5 Have you consumed caffeine or supplements within the past 24-30 hours? (if yes, How much caffeine or which supplements?) Yes No
- 6 _____
Have you been fasting for more than 4 hours? (if yes, when did you last eat?) Yes No
- 7 _____
Do you feel dehydrated? (if yes, when did you last drink fluids?) Yes No
- 8 _____
Have you started or stopped taking any medications (or changed doses) since your last physical exam? If yes, please explain Yes No
- 9 _____
Take a few minutes to review the activity sheet(s) for the test you will be performing today. Do you have any concerns about being able to complete these tasks safely? If yes, please explain Yes No
- 10 _____
Have you had any illness or injury that required you to see or seek healthcare since your last physical exam? Yes No
- 11 Are you pregnant or could you possibly be pregnant? Yes No
- 12 Have you experienced any of the following conditions since your last physical exam with your physician? (if yes, please circle) Yes No
 - Shortness of breath
 - Wheezing
 - Pain or tightness in your chest
 - Irregular heartbeat
 - High or low blood pressure
 - Fainting or dizzy spells
 - Any other lung or heart problems
 - Unusual, severe headaches
 - Numbness or tingling in extremities
 - Pain or discomfort in your legs associated with walking
 - Have you had a seizure

Participant Signature

Date

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***To be completed by the Medical Monitor ***

Date _____ Participant Name _____

- Tests to be done: Fit Testing Cold Temperature♥ Noise Level Man Test 1♥
 Man Test 2♥* Man Test 3♥* Man Test 4♥* Man Test 5 Man Test 6
 Breathing Gas Determination♥ LTFE Treadmill♥ Multiple-Workrate Treadmill♥*
 Other: _____

Pre-Test Examination

Vital Signs		Session Start Time:			
Temperature					
O ₂ saturation on RA					
Respirations/minute					
Heart rate/minute					
Blood pressure		Right/Left			
System	WNL	ABN	System	WNL	ABN
			Cardiovascular		
Alert, oriented, calm, no acute distress, Other:			Regular rate and rhythm		
HEENT			No heaves/thrills		
PERRLA			No Murmurs		
EOMI, NCAT			Other:		
Pink and moist mucous membranes in oropharynx			Musculoskeletal		
Other:			Gait NI		
Respiratory			ROM NI		
CTAB, NI excursion, No W/R/R					
Other:			Other:		
Abdomen			Neurological		
Soft, flat, non-tender, and non-distended, BS pos.			Reflexes and strength NI		
Other:			Other:		

WNL: Within Normal Limits, ABN: Abnormal, NA: Not Assessed

Abnormal findings or additional comments: _____

Pre- and Post-Test Session Participant Questionnaire and Examination

I certify that I have examined the subject and completed the Pre-Test Evaluation:

- No exclusions identified Excluded from participation

Post-Test Examination

Vital Signs	Session End Time:
Temperature	
O ₂ saturation on RA	
Respirations/minute	
Heart rate/minute	
Blood pressure	Right/Left

System	WNL	ABN	System	WNL	ABN
			Cardiovascular		
Alert, oriented, calm, no acute distress, Other:			Regular rate and rhythm		
HEENT			No Carotid Bruits		
PERRLA			No Murmurs		
EOMI, NCAT			Other:		
Pink and moist mucous membranes in oropharynx			Musculoskeletal		
Other:			Gait NI		
Respiratory			ROM NI		
CTAB, NI excursion, No W/R/R					
Other:			Other:		
Abdomen			Neurological		
Soft, flat, non-tender, and non-distended			Reflexes and strength NI		
Other:					

WNL: Within Normal Limits, ABN: Abnormal, NA: Not Assessed

Abnormal findings or additional comments: _____

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Medical Monitor Printed Name: _____

Signature _____ Date: / / Time: _____ AM/PM

Participant denies any issues or complaints. They state that they feel “well” and are discharged from testing today.

Other _____

Signature _____ Date: / / Time: _____ AM/PM