AFROTC PHYSICAL HEALTH SCREENING QUESTIONNAIRE

TO THE CADET: IT IS MANDATORY YOU COMPLETE THIS QUESTIONNAIRE PRIOR TO AND DURING YOUR PARTICIPATION IN THE AIR FORCE RESERVE OFFICER TRAINING CORPS (AFROTC) CADET PHYSICAL TRAINING (PT) PROGRAM.

INSTRUCTIONS

1. IF YOU ARE STARTING THE PT PROGRAM, PRINT TODAY'S DATE UNDER THE COLUMN MARKED "FIRST PT ACTIVITY." IF YOU ARE TAKING A PHYSICAL FITNESS ASSESSMENT (PFA), AND/OR QUALITY FITNESS REVIEW (QFR), CIRCLE THE APPLICABLE ACTIVITY IN THE "PFA/QFR" COLUMN AND PRINT TODAY'S DATE UNDERNEATH.

2. REVIEW EACH QUESTION AND CIRCLE "YES" OR "NO" AS APPLICABLE TO YOUR SITUATION.

3. DATE, PRINT YOUR NAME, AND SIGN AT THE BOTTOM IN THE AREA APPLICABLE TO YOUR SITUATION.

4. RETURN THE COMPLETED QUESTIONNAIRE TO YOUR DETACHMENT CADRE. PLEASE ADVISE THE CADRE IF YOU RESPONDED "YES" TO ANY OF THE QUESTIONS BELOW. ANY "YES" ANSWERS WILL REQUIRE A CONSULTATION WITH A HEALTH CARE PROVIDER BEFORE PARTICIPATING IN ANY PHYSICAL TRAINING ACTIVITIES.

5. YOU MUST COMPLETE AND SUBMIT THIS QUESTIONNAIRE **NLT 72 HOURS PRIOR** TO YOUR INITIAL PT ACTIVITY, PFA, OR QFR.

QUESTION	FIRST PT ACTIVITY DATE ______________	PFA/QFR DATE ______________
1. HAS THERE BEEN ANY SIGNIFICANT CHANGE TO YOUR HEALTH IN THE PAST 6 MONTHS?	YES - NO	YES - NO
2. ARE YOU CURRENTLY ON A MEDICAL PROFILE EXEMPTING YOU FROM ANY COMPONENT OF THE PT ACTIVITIES?	YES - NO	YES - NO
3. HAS A PHYSICIAN EVER INDICATED YOU HAVE HEART DISEASE OR HEART TROUBLE?	YES - NO	YES - NO
A. DO YOU SUFFER FROM PAINS IN YOUR CHEST, ESPECIALLY WITH PHYSICAL ACTIVITY?	YES - NO	YES - NO
B. DO YOU FEEL FAINT OR HAVE DIZZY SPELLS DURING OR AFTER PHYSICAL ACTIVITY?	YES - NO	YES - NO
4. HAVE YOU BEEN DIAGNOSED OR EXPERIENCED AN ASTHMA OR RESPIRATORY CONDITION?	YES - NO	YES - NO
5. HAVE YOU EXPERIENCED A WEIGHT CHANGE GREATER THAN 9 POUNDS IN THE PAST 6 MONTHS?	YES - NO	YES - NO
A. IF "YES", INDICATE THE ESTIMATED AMOUNT GAINED OR LOST: ____________ LBS.		
6. HAVE YOU EVER BEEN DIAGNOSED OR DISPLAYED SYMPTOMS OF HEAT STRESS?	YES - NO	YES - NO
7. FEMALES ONLY: ARE YOU PREGNANT OR DO YOU THINK YOU MAY BE PREGNANT?	YES - NO	YES - NO
8. ARE YOU CURRENTLY TAKING ANY SUPPLEMENTS OR MEDICATION, WHICH CONTAIN ANY OF THE FOLLOWING SUBSTANCES: EPHEDRA/EPHEDRINE, GUARANA, PHENYLEPHRINE, PSEUDOEPHEDRINE?	YES - NO	YES - NO

A. IF YOU ANSWER "YES", LIST THE ITEMS BELOW AND STATE THE LAST TIME YOU TOOK THAT SUPPLEMENT OR MEDICATION.

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FIRST PT ACTIVITY

DATE ______________ PRINT NAME ______________________________________

SIGNATURE ______________________________________

PFA/QFR

DATE ______________ PRINT NAME ______________________________________

SIGNATURE ______________________________________

AFROTC FORM 29, 20080422