

## **HEALTH SCREENING QUESTIONNAIRE (HSQ)**

***Assess your health needs by marking all true statements.***

The purpose is to identify individuals who may be at risk in 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. The questions were designed, in consultation with occupational health physicians, to identify individuals who may be at risk when taking a WCT. The HSQ is not a medical examination. Any medical concerns you have that place you or your health at risk should be reviewed with your personal physician prior to participating in the WCT.

Check 'Yes' or 'No' in response to the following questions:

- Y N 1) During the past 12 months have you at any time (during physical activity or while resting) experienced pain, discomfort or pressure in your chest.
- Y N 2) During the past 12 months have you experienced difficulty breathing or shortness of breath, dizziness, fainting, or blackout?
- Y N 3) Do you have a blood pressure with systolic (top #) greater than 140 or diastolic (bottom #) greater than 90?
- Y N 4) Have you ever been diagnosed or treated for any heart disease, heart murmur, chest pain (angina), palpitations (irregular beat), or heart attack?
- Y N 5) Have you ever had heart surgery, angioplasty, or a pace maker, valve replacement, or heart transplant?
- Y N 6) Do you have a resting pulse greater than 100 beats per minute?
- Y N 7) Do you have any arthritis, back trouble, hip /knee/joint /pain, or any other bone or joint condition that could be aggravated or made worse by the Work Capacity Test?
- Y N 8) Do you have personal experience or doctor's advice of any other medical or physical reason that would prohibit you from taking the Work Capacity Test?
- Y N 9) Has your personal physician recommended against taking the Work Capacity Test because of asthma, diabetes, epilepsy or elevated cholesterol or a hernia?

Regardless whether you are taking the Work Capacity test at the Arduous, Moderate or Light duty level, a "Yes" answer requires a determination from your personal physician stating that you are able to participate. For Arduous Duty Employees, if you do not have a personal physician determination allowing you to take the Work Capacity Test, the FMO may request an Annual Form examination through the Interagency Wildland Firefighter Medical Standards Program.

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

NAME: \_\_\_\_\_ DATE \_\_\_\_\_

### **Privacy Statement**

The information obtained in the completion of this form is used to help determine whether an individual being considered for wildland firefighting can carry out those duties in a manner that will not place the candidate unduly at risk due to inadequate physical fitness and health. Its collection and use are covered under Privacy Act System of Records OPM/Govt-10 and are consistent with the provisions of 5 USC 552a (Privacy Act of 1974).

### **Paperwork Reduction Act Statement**

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