

## RISK ASSESSMENT QUESTIONNAIRE WORKSHEET

<b>PRIVACY ACT STATEMENT</b>	
<b>AUTHORITY:</b>	Title 5, U.S. Code, 301, OPNAVINST 6110.1F
<b>PRINCIPAL PURPOSE:</b>	To provide the Command Fitness Leader with the necessary information to screen personnel for potential health risks prior to physical readiness testing.
<b>ROUTINE USE:</b>	For official and employees of the Department of the Navy in performing their official duties of administering the Health and Physical Readiness Program.
<b>MANDATORY DISCLOSURE AND CONSEQUENCES OF REFUSAL TO DISCLOSE:</b>	Disclosure is necessary to fully evaluate member's readiness to participate in mandatory physical readiness testing. Failure to provide the requested information may preclude participation in physical readiness testing and may warrant further medical evaluation or administrative action.

Command Fitness Leaders shall utilize these risk factor questions to determine all members' risk for exercise-related injuries. Members answering 'Yes' to any question except tobacco use, shall be evaluated by the medical department prior to participation in the PRT and exercise programs (command-sponsored or self-directed).

<i>Member's SSN</i>	<i>CFA Cycle</i>	<i>Member's Name</i>
<p>Please check the box adjacent to 'Yes' or 'No' in response to each of the below listed questions. Check only 'Yes' or 'No' and do not leave any questions blank. When you have answered all questions, sign and date this worksheet in the spaces provided below and then return it to the Command Fitness Leader.</p>		
<b>Section 1</b>		
1. Are you a male greater than 40 years old or a female greater than 50 and do not participate in a consistent aerobic exercise activity three to five times weekly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Has your mother or sister died without any explanation (sudden death) or suffered from a heart attack before the age of 55?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has your father or brother died without any explanation (sudden death) or suffered from a heart attack before the age of 45?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Are you a current tobacco user?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Do you have high blood pressure or are you on blood pressure medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Has a doctor ever told you that you have high cholesterol or are you on cholesterol medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Do you have diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Are you sedentary (don't exercise at least three to five times per week for at least 30 minutes)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Section 2</b>		
1. Do you feel pain in your chest, neck, jaw, or arms when doing physical activity?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you experience any shortness of breath with moderate continuous exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. In the last month have you felt chest pain at rest?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you had any problems with light-headedness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Do you have a known cardiac (heart) disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you experienced episodes of rapid beating or fluttering of the heart?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you unintentionally lost or gained more than 10 percent of your body weight since the last PFA cycle?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Do you suffer from lower leg swelling of both legs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Do you have difficulty breathing or have sudden breathing problems at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Do you have a bone, joint, or muscle problem that may prevent you from doing physical activity of any kind?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Do you have any personal history of metabolic disease (thyroid, renal, liver)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<i>Member's Signature</i>		<i>Date Questionnaire Completed</i>