



**5. Do one (1) or more of the following risk factors apply to you? Note: this question only applies if you answered "No" to question 4.**

- a. Smoked tobacco products in the last 30 days
- b. Diabetes
- c. High blood pressure OR high cholesterol that is not controlled
- d. Family history of heart disease (developed in father/brother before age 55 or mother/sister before age 65)
- e. Age > 45 years for males; > 55 years for females
- f. Diagnosed previously with COVID-19 AND have NOT been cleared for physical activity by a healthcare provider

**Have you answered "Yes" to ANY of the above conditions in block 5?**

**Yes: Stop.** Notify your UFPM that you are not cleared for your fitness test. Complete the remainder of your questionnaire and hand carry this form to medical evaluation.

**No: Stop.** Sign form and return to your UFPM. Airman may take the FA if they were not disqualified by question 1-4.

By signing below, I affirm that this questionnaire was filled out truthfully. Further, I acknowledge that if I recognize any of the following warning signs I should stop my fitness immediately and seek medical attention:

- a. Unexplained chest pain
- b. Shortness of breath
- c. Dizziness
- e. Blurry vision
- f. Unusual leg pain, cramping, and or weakness

**Date:**

**Signature:**

**CONTROLLED UNCLASSIFIED INFORMATION PRIVACY SENSITIVE**

**To Be Completed By Medical**

If medical evaluation is required IAW this FSQ, the provider will complete the following.

\*\*\*\*\*

I medically evaluated \_\_\_\_\_ on \_\_\_\_\_.

RANK, NAME

DATE

Medical recommendations are:

Member (is/is not) medically cleared for best effort on the maximal effort 1.5 mile run.

Member (is/is not) medically cleared for best effort on the sub maximal effort 2.0 km walk.

Member (is/is not) medically cleared for push-ups.

Member (is/is not) medically cleared for sit ups.

**NOTE:** An AF Form 469 has been initiated if appropriate. Airmen with fitness limitations greater than 30 days should be given an exercise prescription in accordance with AFMAN 36 2905.

\_\_\_\_\_  
(SIGNATURE/STAMP OF PROVIDER)