FTC-0TS-6 (7/06)

Health Questionnaire
U.S. DEPARTMENT OF HOMELAND SECURITY
Federal Law Enforcement Training Center

Name	Age	DOB	Class	Date

1. Check each item listed with a yes or no response:

Yes	No		Yes	No		Yes	No	
❑	❑	Diabetes	❑	❑	HIV (AIDS)	❑	❑	CNS (Neurological Disease: i.e. Stroke, Chronic Headache, Epilepsy, other)
❑	❑	High Blood Pressure	❑	❑	Hepatitis (Yellow Jaundice)			
❑	❑	Heart Disease	❑	❑	Positive TB Skin Test	❑	❑	Orthopedic problem (i.e. bone, joint, muscle and/or tendon)
		❑ Rheumatic Heart	❑	❑	STD (Venereal Disease)			
		❑ MVP (Mitral Valve Prolapse)	❑	❑	Pulmonary Disease (Emphysema)	❑	❑	Bowel (Intestinal Stomach Disease)
		❑ Other	❑	❑	Asthma	❑	❑	Tobacco use (Pks/day) _____
						❑	❑	Alcohol Use (Drinks/day) _____

If any of the following apply to you, respond with a brief explanation that includes the year of occurrence. Every item must have a response. If the item does not apply, respond N/A in the space provided.

Height _____ Weight _____

2. Type of exercise performed on a regular basis and frequency _____

3. Unusual shortness of breath on exertion (or exercise) _____

4. Joint problem (any kind) past or present (Provide part of your body feeling pain/swelling, or has had dislocation, broken bones, sprains) _____

5. Back Problems (any kind) past or present _____

6. Frequent dizziness or unconsciousness _____

7. Heart problems (i.e. chest pain, racing heart/skipped beats, abnormal EKG, enlarged heart, heart murmur, family history of sudden cardiac death) _____

8. Recent or serious illnesses or hospitalizations (specify) (i.e. head injury, kidney/ bladder/urine problems) _____

9. Surgery (Include month/year, type) _____

10. Abnormal blood test, past or present (i.e. mononucleosis, anemia) _____

11. Eye problems (any type) (i.e. prior complicated OC spray exposure or allergy, & Lasik surgery and date) _____

12. Physical activity/Exercise restriction (any type) _____

13. Heat Illness/heat exhaustion Problem (how often & date of last event) _____

14. Other medical problems or deformities (any kind) _____

15. List medication(s) currently taking (prescription, over the counter, supplements) _____

16. List any allergic reactions to medications, food or insect bites _____

17. Gyn problems (specify) _____

Are you pregnant? ❑ Yes ❑ No

First day of last menstrual period _____

Menstrual period: ❑ *Regular* ❑ Irregular

18. Have you attended a FLETC training program prior to this training?

❑ Yes ❑ No

PRIVACY ACT NOTICE

The following information is provided in accordance with the Privacy Act of 1974 (5) U.S. C. 552a(e)(3): Authority for the collection of this information is 5 U.S.C. 301, 5 U.S.C. 4101 et seq., Executive Order No. 11348 and the DHS Delegation Number 7950. The primary use of this information is to evaluate fitness to participate in training activities conducted at the FLETC and provide historical health information necessary to plan and deliver treatment while on the FLETC. Routine uses of this information as established and published in accordance with 5 U.S.C .a (3)(4) (D), include transfer of this information to officials of the FLETC and your agency. Disclosure of this information is voluntary. However, it may not be possible for you to receive training at the FLETC if the information is not provided. **Under penalty of perjury, I swear or affirm that the information which I have provided is true to the best of my knowledge.**

_____

Signature

Physician's Comments: _____