DEPARTMENT OF HOMELAND SECURITY

FEDERAL LAW ENFORCEMENT TRAINING CENTERS HEALTH QUESTIONNAIRE

Full Name (Last, First, Middle)	Age	DOB	Class	Agency	Date

Address	Work Email	Phone Number

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

Yes	No		Yes	No	
☐	☐	Diabetes	☐	☐	Pulmonary Disease (Emphysema)
☐	☐	High Blood Pressure	☐	☐	Asthma
☐	☐	Heart Disease	☐	☐	Alcohol (Drinks/Day)
☐	☐	Rhabdomyolysis	☐	☐	Tobacco Use (Packs/Day)
☐	☐	HIV (AIDS)	☐	☐	CNS (Neurological Disease: stroke, seizures, migraines)
☐	☐	Hepatitis	☐	☐	Orthopedic Problems (bone, joint, muscle, tendon)
☐	☐	Positive TB Skin Test	☐	☐	Gastrointestinal Disorders (ulcers, etc.) Other:

Height _____

Weight _____

Sex Male ☐ Female ☐

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.

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

3. Unusual shortness of breath on exertion (or exercise) Yes ☐ No ☐

4. Joint problem (any kind) past or present (Provide part of your body feeling pain/swelling, or has had dislocation, broken bones, sprains) (month/year occurrence) Yes ☐ No ☐

5. Back Problems (any kind) (month/year occurrence) Yes ☐ No ☐

6. Frequent dizziness or unconsciousness Yes ☐ No ☐

7. Heart problems (i.e. chest pain, racing heart/skipped beats, abnormal EKG, enlarged heart, heart murmur, family history of sudden cardiac death) Yes ☐ No ☐

8. Recent infections, serious illnesses or hospitalizations (head injury, urinary problems, viral or bacterial infections, etc.) Yes ☐ No ☐

9. Surgery (Include month/year, type) Yes ☐ No ☐

10. Abnormal blood test, past or present (i.e. mononucleosis, anemia) Yes ☐ No ☐

11. Eye problems (any type) (i.e. prior complicated OC spray exposure or allergy, & Lasik surgery and date) Yes ☐ No ☐

12. Physical activity/Exercise restriction (any type) Yes ☐ No ☐

13. Heat Illness/heat exhaustion Problem (how often & date of last event) Yes ☐ No ☐

14. Other medical problems or deformities (any kind)

15. List medication(s) currently taking (prescription, over the counter, supplements) Medication Name, Dosage, Frequency

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

17. Gynecological problems (specify) _____

18. Are you pregnant? Yes ☐ No ☐

19. 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.

[redacted]

Trainee Signature

Health Unit Staff Use ONLY Below this Line

☐ CLEARED FOR TRAINING

Blood Pressure: _____/_____

☐ NOT CLEARED FOR TRAINING:

Provider Name:

Comments:

Reset Form