RISK FACTOR ASSESSMENT

PRIVACY ACT

Information contained on this form is maintained under the Systems of Records Notice DHA 07, Military Health Information System (March 30, 2006, 71 FR 16127). **AUTHORITY:** DoD Health Information Privacy Regulation; 10 U.S.C. 1071-1085 and Reporting of Information;10 U.S.C. 1097a and 1097b. **PRINCIPLE:** PERSONAL IDENTIFICATION DATA: Selected electronic data elements extracted from the Defense Enrollment and Eligibility Reporting System (DEERS) beneficiary and enrollment records that include data regarding personal identification including demographic characteristics. **PURPOSE:** Data collected within and maintained in the system is used for patient administration (including registration, admission, disposition and transfer); patient appointing and scheduling delivery of managed care; workload and medical services accounting; and quality assurance. **ROUTINE USE:** Disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, these records and information contained therein may be disclosed outside the DOD as a routine use pursuant to 5 U.S.C. 552a (b)(3). **DISCLOSURE:** Mandatory for computer matching.

From: _____

To: _____

I understand and agree that I must complete the risk factor screening questionnaire below honestly, Should any risk factor be determined for participation in certain activities, I agree to see the Occupational Health Physician for a release to participate in Command-sponsored physical fitness programs. Once an exercise program has been established for me, I agree to adhere to any limitations.

QUESTIONS	YES	NO
Has a doctor ever said that you have heart trouble, or have you ever had a heart attack?		
Do you have pains or pressure in the chest, neck, shoulders, or arms during or right after you exercise?		
Do you often feel faint; have spells, or severe dizziness?		
Has a doctor said that you have bone or joint problems such as arthritis, which might be aggravated by exercise?		
Do you have a family history of premature coronary artery disease (heart attack or chest pain prior to age 50)?		
Do you have a medical condition not mentioned above that might need special attention in an exercise program (i.e.,insulin dependent diabetes)? If yes, please name your conditon: _____		
Have you ever smoked one or more packages of cigarettes per day for 10 or more years?		
Are you medically diagnosed as obese?		

EMPLOYEE SIGNATURE _____ DATE _____

SUPERVISOR SIGNATURE _____ DATE _____

OCCUPATIONAL HEALTH PHYSICIAN SIGNATURE _____ DATE _____

OR

PERSONAL PHYSICIAN SIGNATURE _____ DATE _____

PHYSICIAN'S COMMENTS:

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