2022 / 2023
FIGHTING FIT PROGRAM

The following questionnaire contains questions on medical, health and lifestyle parameters. The information will be used to identify your health status, to assist in determining your readiness to undertake a physical fitness test and specific firefighting duties.

If you have any questions regarding the information requested, please ask your consultant at your appointment or contact CHG's Fighting Fit Program Coordinator on 8354 9800

NOTE

Please bring your **completed** questionnaire with you to your health assessment appointment.

To ensure we can give you the most accurate results possible in regards to cholesterol and blood pressure, follow the guidelines below:

For 2-3 hours before your assessment please DO NOT:

- **Eat**
- **Smoke**
- **Exercise**
- **Drink (Please continue to drink plain water)**

If you have an early morning appointment an overnight fast is ideal

*****IF ON THE DAY OF YOUR APPOINTMENT YOU HAVE A COLD/FLU OR OTHER ILLNESS, PLEASE RESCHEDULE YOUR APPOINTMENT*.**

To reduce the spread of illness and for the accuracy of the test you will not be able to undertake a spirometry test, therefore cannot complete the full assessment**.**

For staff in regional areas you may need to complete a PARQ form or see your doctor for your clearance when you are feeling better. For metro based staff you can book another date, book at another site, make an appointment at CHG's head office or complete a PARQ form.

Please bring this completed form to your Health Assessment

PLEASE STATE YOUR CURRENT:	
Height (cm)	
Weight (kg)	

Email	
Contact Number	
CFS Member ID	

IF YOU ARE ***NOT*** ATTENDING A MEDICAL PLEASE FORWARD YOUR ***COMPLETED FORM*** TO:

CHG
Tara Baldwin
PO Box 562
TORRENSVILLE SA 5031

E tbaldwin@chg.net.au

What happens next?

- When your form is received it will be reviewed by the Fighting Fit Program Coordinator at CHG.
- Once reviewed your Fighting Fit Regional Contact will be notified of your clearance to undertake the Task Based Assessment.
- If there are any areas of your form requiring clarification we will contact you directly. Please ensure you include your phone number above so we can make contact easily.
- If we require you to seek a medical clearance before participating in the task-based assessment you will be sent the required medical forms.
- These medical forms must be completed by your General Practitioner and returned to CHG before the date of your Task Based Assessments.
- Once the completed medical forms have been completed your assigned medical rating will be forwarded to your Fighting Fit Regional Contact.

PERSONAL DETAILS

Full Name _____

Age _____

DOB / /

Gender ☐ Male ☐ Female

Company ☐ DEW ☐ ForestrySA

Region / Site _____

Date / /

Please answer the following questions which will help assess your fitness for specific duties.

CURRENT MEDICAL HISTORY

Have you had a medical examination with a G.P or specialist in the past two years?	Yes	No
Are being treated by a doctor for any illness or injury at present?	Yes	No
Are you under any medical treatment or take any medications or use an inhaler?	Yes	No
Do you or have you experienced exercise induced hypoglycaemia (low blood sugar)?	Yes	No
Are you pregnant or have you given birth within the last 3 months?	Yes	No
Have you spent time in hospital (including day admission for any medical condition, illness or injury) in the last 12 months?	Yes	No
Has your health been affected by previous employment?	Yes	No

If you have answered **Yes** to any of these questions please provide further information:

SPIROMETRY TEST

Have you coughed blood in the last 48 hours?	Yes	No
Have you had a recent pneumothorax (collapsed lung)?	Yes	No
Do you currently have a suspected infectious disease e.g. influenza, cold?	Yes	No
Have you had pneumonia or bronchitis in the past 3 months?	Yes	No

If you have answered **Yes** to any of these questions please provide further information:

OFFICE USE ONLY

Individual Referred Yes / No

Assessment or PARQ _____

Name of Assessor _____

CARDIO RESPIRATORY

Have you ever had or been told by a doctor, that you have the following?

Heart Disease/stroke or heart condition	Yes	No
Chest pain, angina	Yes	No
High blood pressure	Yes	No
Low blood pressure	Yes	No
High blood sugar	Yes	No
Palpitations or irregular heart beat?	Yes	No
Abnormal shortness of breath	Yes	No
Asthma	Yes	No
Have you had an asthma attack in the last 12 months? What triggered it?	Yes	No
Do any of the following trigger your asthma – grass, smoke, exercise, cold air, dust, chemicals?	Yes	No
Have you ever suffered from heat stroke or heat stress?	Yes	No

If you have answered **Yes** to any of these questions please provide further information:

NEUROLOGICAL

Have you ever had or been told by a doctor, that you have the following?

Severe head injury or spinal injury	Yes	No
Seizures, fits, convulsions, epilepsy	Yes	No
Dizziness, vertigo, problems with balance, blackouts (particularly during activity/exercise/heat)?	Yes	No
Severe headaches or migraines	Yes	No
Sleep disorder, sleep apnoea or narcolepsy	Yes	No
Issues with alcohol or drug use	Yes	No

If you have answered **Yes** to any of these questions please provide further information:

MUSCULOSKELETAL

Have you suffered from the following?

Back or neck pain in the last 12 months?	**Yes**	**No**
Any previous back or neck pain?	**Yes**	**No**
Any knee, ankle, shoulder, hip, elbow, wrist or any other joint pain in the last 12 months?	**Yes**	**No**
Any previous knee, ankle, shoulder, hip, elbow, wrist or other joint pain?	**Yes**	**No**

If you have answered **Yes** to any of these questions please provide further information:

MENTAL STATUS

Have you had any psychiatric or psychological treatment in the last 12 months which might affect your ability to participate in an emergency management role?	**Yes**	**No**

Yes (If yes, please detail)

Do you suffer from claustrophobia or agoraphobia (fear of open spaces)?	**Yes**	**No**
Have you been treated for depression?	**Yes**	**No**
Do you suffer from or are you being treated for anxiety or panic attacks?	**Yes**	**No**

If you have answered **Yes** to any of these questions please provide further information:

GASTRO INTESTINAL

Have you ever had, or been told by a doctor that you have the following?

Peptic ulcer disease	**Yes**	**No**
Bleeding from the bowel	**Yes**	**No**

If you have answered **Yes** to any of these questions please provide further information:

GENERAL PHYSICAL CONDITION

Are you regularly active?		**Yes**	**No**
Please describe your physical activity	**Light**	**Moderate**	**Vigorous**
Average number of sessions per week			
Average duration of a session (minutes)			**mins**

Please describe types of activity/exercise you do:

Have you ever smoked? Includes social or party smokers	**Yes**	**No**
If yes how many cigarettes per day?		
Quit? How long ago?		
Do you drink alcohol?	**Yes**	**No**
If yes, on average how many standard drinks do you have a week?		

SPECIAL SENSES

Do you wear glasses?	**Yes**	**No**
Have you been told you are colour blind?	**Yes**	**No**
Do you have a hearing problem?	**Yes**	**No**

If you answered **Yes** to any of these questions please provide further information:

ALLERGIES

Do you have any allergies?	**Yes**	**No**
Are they related to food, the environment or medications?	**Yes**	**No**

If you have answered **Yes** to this question please provide further information (what you are allergic to, type of reaction, any medication required, severity, etc):

DECLARATION AND AUTHORISATION

I certify that to the best of my knowledge the above information supplied by me is true and correct and I consent to releasing medical information to the Fighting Fit Health Professional in order to assess my medical fitness for continuing in the role of rural firefighter.

I understand that in the event of an injury or illness during work duties, DEW may seek to obtain information relevant to that injury or illness that I have provided in this health questionnaire or during my assessment.

By signing the Authority to Exchange Information below, I give permission for CHG to release information relevant to the injury/ illness to the DEW Fire Management Unit when requested.

I understand that this confidential information relevant to my injury or illness may need to be discussed with my managers and supervisors.

I understand that if I sustain an injury or illness that may impact on my abilities to perform my firefighting duties I must inform my manager and CHG to determine what, if any, restrictions will apply and if I require a medical clearance to return to these duties.

AUTHORITY TO EXCHANGE INFORMATION

Full Name _____

Signature _____

Date / /