Delaware Wildland Firefighter

2026 HEALTH SCREEN QUESTIONNAIRE (HSQ)

The purpose of this questionnaire is to identify individuals who may be at risk in taking the Work Capacity Test (WCT) and to recommend a medical examination prior to taking the WCT.

Delaware wildland firefighters are required to answer the following questions. They were designed, in consultation with occupational health physicians, to identify individuals who may be at risk when taking a WCT. The HSQ is not a medical examination. Any medical concerns you have that place you or your health at risk should be reviewed with your personal physician prior to participating in the WCT.

Circle the appropriate Yes or No response to the following questions:

Yes No 1) During the past 12 months have you at any time (during physical activity or while resting) experienced pain, discomfort or pressure in your chest.

Yes No 2) During the past 12 months have you experienced difficulty breathing or shortness of breath, dizziness, fainting, or blackout?

Yes No 3) Do you have a blood pressure with systolic (top #) greater than 140 or diastolic (bottom #) greater than 90?

Yes No 4) Have you ever been diagnosed or treated for any heart disease, heart murmur, chest pain (angina), palpitations (irregular beat), or heart attack?

Yes No 5) Have you ever had heart surgery, angioplasty, or a pacemaker, valve replacement, or heart transplant?

Yes No 6) Do you have a resting pulse greater than 100 beats per minute?

Yes No 7) Do you have any arthritis, back trouble, hip/knee/joint /pain, or any other bone or joint condition that could be aggravated or made worse by the Work Capacity Test?

Yes No 8) Do you have personal experience or doctor's advice of any other medical or physical reason that would prohibit you from taking the Work Capacity Test?

Yes No 9) Has your personal physician recommended against taking the Work Capacity Test because of asthma, diabetes, epilepsy or elevated cholesterol or a hernia?

Regardless of whether you are taking the Work Capacity test at the Arduous or Moderate duty level, a "Yes" answer requires a determination from your personal physician stating that you are able to participate.

I understand that if I need to be evaluated, it will be based on the fitness requirements of the position(s) for which I am qualified.

Name: _____ ***Signature:*** _____
(Please Print)

----------DO NOT WRITE BELOW THIS LINE----------

DFS Representative: _____ ***Date:*** _____

Time: _____ ***Work Capacity Test Taken: Arduous (3 mile) Moderate (2 mile)***
(Please Circle One)

Practice Shelter Deployment: Y / N ***Results: Pass Fail***
(Please Circle One) *(Please Circle One)*