

DATE: _____ **PERIODIC HEALTH ASSESSMENT (PHA)**

S: SUBJECTIVE

_____ year old () male () female reports for an annual PHA which includes record review/verification, assessment and counseling of health risk factors, clinical preventive services, deployment health history, and individual medical readiness (IMR) assessment.

SCREENING:

Height: (inches)

Weight (pounds)

BMI:

Temperature:

deferred

Pulse:

Respirations:

deferred

Blood Pressure:

Allergies (Medication and other): See Block 1 on DD 2766

Chronic Illnesses: See Block 2 on DD 2766

Medications (Rx / OTC / herbals / supplements / performance enhancers): See Block 3 on DD 2766

Hospitalizations/Surgeries since last PHA: See Block 4 on DD 2766

Family History: See Block 6 on DD 2766

Occupational History: See Block 8 on DD 2766

O: OBJECTIVE

Vital Signs noted. Remarkable for: None Other: _____

Visual Acuity: OD: _____ OS: _____ (Consult if worse than 20/40, no contacts)

Physical examination is otherwise deferred.

- | | | | |
|-------------------------|-----------------------------------|--|---|
| Health Record | <input type="checkbox"/> Reviewed | <input type="checkbox"/> Not Available | <input type="checkbox"/> Remarkable for: _____ |
| Dental Readiness | <input type="checkbox"/> Reviewed | <input type="checkbox"/> Not Available | <input type="checkbox"/> See Plan |
| Dental Classification | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 <input type="checkbox"/> 4 |
| Immunization Record | <input type="checkbox"/> Reviewed | <input type="checkbox"/> Not Available | <input type="checkbox"/> See Plan |
| Lab/Path Results | <input type="checkbox"/> Reviewed | <input type="checkbox"/> Not Available | <input type="checkbox"/> See Plan |
| Clinical Prev. Services | <input type="checkbox"/> Reviewed | <input type="checkbox"/> Not Available | <input type="checkbox"/> See Plan |
| Occupational Health | <input type="checkbox"/> Reviewed | <input type="checkbox"/> Not Available | <input type="checkbox"/> See Plan |
| Hearing Assessment | <input type="checkbox"/> Reviewed | <input type="checkbox"/> Not Available | <input type="checkbox"/> See Plan |

Deployment Health: See DD 2766

Deployed since previous PHA? Yes No

Post-Deployment Health Assessment (DD 2796) in record? Yes No

Post-Deployment Health Reassessment (DD 2900) in record? Yes No

Any unresolved deployment-related issues or health concerns? Yes No

Comments: _____

MEDICAL EQUIPMENT:

Prescription Lenses (two pairs)

Y N NA

Ballistic Eyewear

Y N NA

Gas Mask Inserts

Y N NA

Medical Alert Tags

Y N NA

A: ASSESSMENT

Health Risk Assessment: Completed and reviewed? Yes No

Health Risk Assessment Level: High Med Low

Cardiovascular Screening (Framingham 10-year risk for Event/Death): _____

Pain Assessment (zero pain to severe): 0 1 2 3 4 5 6 7 8 9 10

Location: _____

Any other current health concerns? _____

PATIENT'S IDENTIFICATION
(Use this space for mechanical imprint, telephone number, and e-mail address for follow-up):

| | | |
|--|--------|---------------|
| PATIENT'S NAME (Last, First, Middle Initial) | | SEX |
| SSN / IDENTIFICATION NO. | STATUS | RANK/GRADE |
| RECORDS MAINTAINED AT | | DATE OF BIRTH |

PERIODIC HEALTH ASSESSMENT (PHA) (Continued)

Duty Status Assessment

On Limited Duty (LIMDU) Yes No NA Comments: _____
Medical Board Yes No NA Comments: _____
 TNPQ TNDQ NPQ LOD NA Comments: _____

P: PLAN / P: PREVENTION

1. Updated DD 2766 Sections: 1 2 3 4 5 6 7 8 9 10 11
2. Health counseling performed and documented on the DD 2766: Yes No
3. Labs ordered for the following: Blood Type and RH G6PD HIV DNA Lipids
 Others as required by geographic, occupation, or ISIC _____
Electronic verification complete: Yes No
4. Immunizations ordered for the following: MMR Tdap (1 time booster) or Td IPV Influenza
 Hep A #1 #2 Hep B #1 #2 #3 (required for all new recruits) TWINRIX® may be used (3 shots required)
Other immunizations: _____ _____ _____
Electronic verification complete: Yes No
5. Tuberculosis Screening: PPD Placement: _____ Results: _____
6. Clinical Preventive Services recommended: Pap Chlamydia Mammogram Colorectal
 Clinical Breast Exam Testicular Exam Prostate Cholesterol
 Other: _____
7. Referred to Dental for: Annual T-2 Dental Exam Dental Class 3 Dental Class 4 Bitewings Panograph
8. Referred to PCM for: Physical Fitness Clearance Deployment-Related Condition
 Current Medications / Supplements Chronic Medical Conditions Current Illness / Injury
 Other: _____
9. Referred for Preventive / Healthy Lifestyle Counseling:
 Tobacco Use Physical Activity Safety Alcohol Use Dental Care Nutrition Mental Health
 Sexuality Other _____
10. Other indicated referrals:
 Audiology Optometry Behavioral Health OB / GYN Dietician OCC Health
 Chaplain DAPA FFSC Semper Fit Weight Management
 Other: _____
11. Member readiness reviewed Yes No and updated in approved electronic data system Yes No
Member is fully medically ready and requires no follow-up at this time: Yes No
12. Additional Comments: _____

13. Member informed that completion of recommended tests / immunizations / screenings is to be performed within the next 30 days, and he/she is personally responsible for maintaining IMR. Service Member received health risk prevention / healthy lifestyle counseling and voiced understanding.

Member Signature: _____ Date: _____
HM / MDR Signature: _____ Date: _____
Provider Signature: _____ Date: _____