PERIODIC HEALTH ASSESSMENT (CIVILIAN PROVIDER)

Authority: 5 U.S.C. 301, Departmental Regulations; 10 U.S.C. 1095, Collection from Third Party Payers Act; 10 U.S.C. 5131 (as amended); 10 U.S.C. 5132; 44 U.S.C. 3101; 10 CFR part 20, Standards for Protection Against Radiation; and, E.O. 9397 (SSN). **Purpose:** This system is used by officials, employees and contractors of the Department of the Navy (and members of the National Red Cross in naval medical treatment facilities) in the performance of their official duties relating to the health and medical treatment of Navy and Marine Corps members; physical and psychological qualifications and suitability of candidates for various programs; personnel assignment; law enforcement; dental readiness; member's physical fitness for continued naval service. **Routine uses**: In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, these records or information contained therein may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. 552a(b)(3); When required by federal statute, by executive order, or by treaty, medical record information will be disclosed to the individual, organization, or government agency, as necessary. The DoD 'Blanket Routine Uses' that appear at the beginning of the Navy's compilation of system of records notices also apply to this system. **Disclosure:** Voluntary. However, failure to provide the requested information may result in failure to receive required treatment and future benefits.

1. SERVICE MEMBER'S NAME (Last, First, Middle Initial)	**2. SOCIAL SECURITY NUMBER**	**3. BRANCH OF SERVICE**

4. UNIT OF ASSIGNMENT	**5. UNIT ADDRESS**

6. SUBJECTIVE **AGE**:_____

ALLERGIES (Medications and other): _____

CHRONIC ILLNESSES with date of onset:_____

MEDICATIONS/Supplements/Food/Rx/OTC (dosage and frequency):_____

_____

SURGERY/HOSPITALIZATIONS (Hx of all):_____

_____

ILLNESSES/INJURIES in last 12 months: _____

_____

FAMILY RISK FACTORS (with date of onset): Heart Disease_____ High Blood Pressure_____ Diabetes_____ Cancer_____
Other- Please Specify_____

TOBACCO USE ☐ NO ☐ YES List quantity/frequency of current and past use_____

ALCOHOL USE ☐ NO ☐ YES List quantity and frequency of use_____

7. OBJECTIVE

VITAL SIGNS: Height (inches) _____ Weight (pounds) _____ BMI _____ Temp _____ Blood Pressure _____/_____ Pulse _____
Respirations _____

DISTANT VISUAL ACUITY: OS_____ OD_____ **NEAR VISUAL ACUITY: OS_____ OD_____**

BODY SYSTEMS REVIEW	**NORMAL**	**COMMENTS**
a. General Appearance	☐ YES / ☐ NO	
b. HEENT	☐ YES / ☐ NO	
c. Lymph Glands	☐ YES / ☐ NO	
d. Cardiovascular (Auscultation)	☐ YES / ☐ NO	
If Murmur present	Standing makes it:	☐ Louder ☐ Softer ☐ No Change
	Squatting makes it:	☐ Louder ☐ Softer ☐ No Change
	Valsalva makes it:	☐ Louder ☐ Softer ☐ No Change
e. Vascular		
Carotid Pulses	☐ YES / ☐ NO	
Femoral Pulses	☐ YES / ☐ NO	
Pedal Pulses	☐ YES / ☐ NO	
f. Lungs: Auscultation/Percussion	☐ YES / ☐ NO	
g. Chest Contour	☐ YES / ☐ NO	
h. Skin	☐ YES / ☐ NO	
i. Abdomen and Viscera	☐ YES / ☐ NO	
j. Genito-urinary	☐ YES / ☐ NO	
k. Extremities	☐ YES / ☐ NO	
l. Spine, other musculoskeletal	☐ YES / ☐ NO	
m. Gross neurological (reflexes)	☐ YES / ☐ NO	

8. ASSESSMENT

GENERAL HEALTH ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Examiner's Comments: _____

_____

9. PLAN

a. LABS ORDERED: ☐ LIPID PANEL ☐ THYROID ☐ CBC ☐ BMP ☐ CMP ☐ OTHER_____

b. CLINICAL PREVENTIVE SERVICES RECOMMENDED: ☐ Colonoscopy ☐ Mammogram ☐ Pap Test ☐ Prostate ☐ Hearing Assessment

☐ Other_____

c. PREVENTIVE/HEALTHY LIFESTYLE COUNSELING: ☐ Smoking Cessation ☐ Weight Reduction ☐ Stress Management

d. OTHER REFERRALS_____

10. PROVIDER'S NAME (Last, First, Middle Initial)	**11. PROVIDER'S ADDRESS** (Street, City, State, 9-digit Zip Code)
12. PROVIDER'S TELEPHONE NUMBER (Include Area Code)	
13. PROVIDER'S SIGNATURE/STATE LICENSE NUMBER	**14. DATE OF EXAMINATION** (DD/MM/YYYY)

15. MILITARY USE BELOW THIS LINE

a. Date Fleet and Marine Corps Health Risk Assessment completed (DD/MM/YYYY): _____

b. Date counseling completed (DD/MM/YYYY): _____

c. Immunizations provided this date: _____ Date HIV drawn (<2yrs): _____

d. Medication prescriptions reviewed: ☐ YES / ☐ NO / ☐ NA

e. Corrective lenses prescription reviewed: ☐ YES / ☐ NO / ☐ NA

f. Date dental exam completed (DD/MM/YYYY): _____ Dental Class ☐ I ☐ II ☐ III ☐ IV

g. Required medical equipment: ☐ Prescription glasses (2 pair) ☐ Gas Mask Inserts (1 pair) ☐ Contacts

☐ Hearing Aids ☐ Medical Alert Tag (Red Dog Tags)

h. Deployment History: Deployed since the previous PHA? ☐ Yes ☐ No

Post-Deployment Health Assessment (DD2796) in record? ☐ Yes ☐ No

Post-Deployment Health Re-Assessment (DD2900) in record? ☐ Yes ☐ No

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

☐ Member fit for full duty

☐ Member placed in ☐ TNPQ / ☐ TNDQ / ☐ MRR / ☐ LOD status for: _____

MEMBER'S SIGNATURE_____ **DATE**_____

PROVIDER'S SIGNATURE_____ **DATE**_____

COUNSELOR/MDR'S SIGNATURE_____ **DATE**_____