DATE:

SCREENING:

Height: (inches)

Weight (pounds)

BMI:

Temperature:

deferred

Pulse:

Respirations:

deferred

Blood Pressure:

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

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.

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	☐ Reviewed	☐ Not Available	☐ Remarkable for: _____	
Dental Readiness	☐ Reviewed	☐ Not Available	☐ See Plan	
Dental Classification	☐ 1	☐ 2	☐ 3	☐ 4
Immunization Record	☐ Reviewed	☐ Not Available	☐ See Plan	
Lab/Path Results	☐ Reviewed	☐ Not Available	☐ See Plan	
Clinical Prev. Services	☐ Reviewed	☐ Not Available	☐ See Plan	
Occupational Health	☐ Reviewed	☐ Not Available	☐ See Plan	
Hearing Assessment	☐ Reviewed	☐ Not Available	☐ 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: _____

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: _____