PERIODIC HEALTH ASSESSMENT (PHA)

NAVY ACTIVE COMPONENT (AC)

DATE:
Time Start:

SCREENING:
Height: (inches)

Weight: (pounds)

BMI:

Temperature:

deferred
Respirations:

deferred
Blood Pressure:

Pulse:

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

S: SUBJECTIVE

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

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

Deployment Health: See Block 11 on DD 2766
Deployed since the previous PHA? ❑ Yes ❑ No
Post-Deployment Health Assessment (DD 2796) in record? ❑ Yes ❑ No ❑ NA
Any unresolved deployment-related issues or health concerns? ❑ Yes ❑ No ❑ NA

Health Assessment Report Tool: Completed and reviewed? ❑ Yes ❑ Not available
Any other current health concerns? _____

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

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 Classification	❑ Reviewed	❑ Not available	❑ See Plan: Dental
Immunization record	❑ Reviewed	❑ Not available	❑ See Plan: Immunizations
Lab/Path results	❑ Reviewed	❑ Not available	❑ See Plan: Laboratory
Clinical Prev. Services	❑ Reviewed	❑ Not available	❑ See Plan: CPS
Occupational Health	❑ Reviewed	❑ Not available	❑ See Plan: OH

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) - AC (Continued)

A: ASSESSMENT Annual Periodic Health Assessment visit

1. Health Assessment Report Tool Risk Level: High Med Low
   Health Risks remarkable for the following: _____
2. Cardiovascular Screening (Framingham 10-year risk for Event/Death): _____
3. Other significant issues remarkable for: _____

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 and remarkable for additional topics below:
   _____
3. Labs ordered for the following: ❑ Blood Type ❑ G6PD ❑ HIV ❑ DNA ❑ Lipids
   ❑ Other: _____
4. Immunizations ordered for the following: ❑ PPD ❑ MMR ❑ Td ❑ DIPV ❑ Influenza ❑ HepA #1 #2
   ❑ Other: _____
5. Clinical Preventive Services recommended: ❑ Pap ❑ Chlamydia ❑ Mammogram ❑ Lipids ❑ Colorectal
   ❑ Clinical Breast Exam ❑ Testicular Exam ❑ Prostate
   ❑ Other: _____
6. Referred to Dental for: ❑ Annual T-2 Dental Exam ❑ Dental Class 3 ❑ Dental Class 4
7. Referred to PCM for: ❑ Medical Warning Tags ❑ BMI ❑ PFA Clearance ❑ Deployment-Related Condition
   ❑ Current Medications/Supplements ❑ Chronic Medical Conditions ❑ Current Illness
   ❑ Other: _____
8. Referred to Health Promotion for Preventive Counseling:
   ❑ Tobacco Use ❑ Physical Activity ❑ Safety ❑ Alcohol Use ❑ Dental Care ❑ Nutrition ❑ Mental Health
   ❑ Sexuality ❑ Other: _____
9. Other indicated referrals:
   ❑ Audiology ❑ Optometry ❑ Physical Exams ❑ Behavioral Health ❑ OB/GYN ❑ Dietician ❑ Occ Health
   ❑ PrevMed/Epidemiology ❑ Chaplain ❑ DAPA ❑ FFSC ❑ EFMP ❑ Semper Fit ❑ Weight Management
   ❑ Tobacco Cessation ❑ Other: _____
10. PARFQ completed and signed by member and provider.
    Additional risk factors: ❑ None noted ❑ Identified: _____
    Member cleared for PFA participation? ❑ Yes ❑ No (If no, generic SF 600 completed.) Reason for waiver:
    _____
11. Member readiness reviewed and updated in approved electronic data system.
12. Additional Comments:
    _____
    _____
    _____
    _____
    _____
    _____
13. Member informed that completion of recommended tests / immunizations / screenings is to be performed within the next 30 days, and is personally responsible for maintaining individual medical readiness (IMR).
14. F/U in one year.

Provider Signature and Title: _____ Time Completed: _____