This form must be completed electronically. Handwritten forms will not be accepted.

ANNUAL PERIODIC HEALTH ASSESSMENT

PRIVACY ACT STATEMENT

Privacy Act Statement: DD Form 3024 will collect PII that is stored in active duty and reserve servicemembers' medical and military personnel records, a system of records, and retrieved by a personal identifier. Therefore, the Privacy Act applies, and a Privacy Act Statement is required. The attached updated Privacy Act Statement should be provided to individuals prior to their completing or being asked for any of the information requested by DD Form 3024. This updated Privacy Act Statement is needed to ensure the proper SORN is fully cited, the legal authorities are updated to the proper authorities, and the citation to DoD's Blanket Routine Uses of information is removed because those uses are no longer applicable.
This statement serves to inform you of the purpose for collecting personal information as required by DD Form 3024, Annual Periodic Health Assessment, and how the information will be used.
AUTHORITIES: 10 U.S.C., Chapter Ch. 55, Medical and Dental Care; DoDI 6200.06, "Periodic Health Assessment Program"
PURPOSE: To periodically assess the health and well-being of active duty and reserve military servicemembers regarding force readiness and servicemembers' suitability for deployment. Information collected will be used to assess force readiness and recommend proactive health interventions for individuals.
ROUTINE USES: Information in your records may be disclosed to personnel within the Defense Health Agency and Department of Defense for the purposes of documenting the current state of your health and well-being, assessing your suitability for deployment, and recommending proactive health intervention. Any protected health information (PHI), including mental health and substance abuse information, in your records may be used and disclosed generally as permitted by the HIPAA Rules (45 CFR Parts 160 and 164), as implemented by DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.
APPLICABLE SORN: EDHA 07, "Military Health Information System" (June 15, 2020, 85 FR 36190) https://dpcld.defense.gov/Portals/49/Documents/Privacy/SORNs/DHA/EDHA-07.pdf

INSTRUCTIONS: You are highly encouraged to answer all questions. If you do not understand a question, please discuss the question with a health care provider. If this is your first PHA since entering the United States military *(or if you don't know if you've ever had a PHA)* ONLY consider the PAST12 MONTHS when responding to the questions below that say "since your last PHA".

PART A. SERVICE MEMBER QUESTIONS AND RESPONSES *(TO BE COMPLETED BY THE SERVICE MEMBER)*

I. SERVICE MEMBER INFORMATION AND DEMOGRAPHICS *(SMI)*

1. Last Name:	2. First Name:	3. Middle Initial:
4. Today's Date *(dd/mmm/yyyy)*	5. Date of Birth *(dd/mmm/yyyy)*	6. Age:
7.Gender: ☐ Male ☐ Female	8. Provide your 10-digit DoD ID number located on the back of your CAC.	

9. Service Branch:
- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ Coast Guard
- ☐ Other *(List)*: _____ *(Skip to 16)*

10. Component:
- ☐ Active Duty
- ☐ National Guard
- ☐ Reserves

11. STATUS:
- ☐ Active Duty
- ☐ Traditional Guardsman
- ☐ Drilling Reservist *(TPU, IMA)*
- ☐ Active Guard Reserve *(AGR)* or Full-Time Support *(FTS)*
- ☐ Individual Ready Reserve *(IRR)*
- ☐ Inactive National Guard *(ING)*
- ☐ Other *(List)*: _____

12. Pay Grade:

☐ E1	☐ O1	☐ W1	
☐ E2	☐ O2	☐ W2	
☐ E3	☐ O3	☐ W3	
☐ E4	☐ O4	☐ W4	
☐ E5	☐ O5	☐ W5	
☐ E6	☐ O6	☐ Other *(List)*:	_____
☐ E7	☐ O7		
☐ E8	☐ O8		
☐ E9	☐ O9		
	☐ O10		

13. Unit Name:	14. Duty Station/Location:

15. What is your Unit Identification Code *(for Army, Navy, Coast Guard)*, or Reporting Unit Code *(for Marine Corps)*?

16. Is this your first Periodic Health Assessment *(PHA)*? ☐ Yes ☐ No ☐ Don't Know

17. Are you enrolled in a secure messaging system with your health care provider *(RelayHealth, MiCare, or Patient Portal)*? *(For Active Duty or Active Guard Reserve (AGR)/Full-time Support (FTS))* ☐ Yes ☐ No ☐ Don't Know

18. Current contact information *(Select preferred method)*:		19. Point of contact who can always reach you *(No health or medical information will be shared with your point of contact)*:	
☐ DSN Phone:		Name:	
☐ Day Time Phone:		Phone 1:	
☐ Night Time Phone:			
☐ Email 1:		Phone 2:	
☐ Email 2:			
☐ RelayHealth, MiCare, Patient Portal: (*If applicable*)		Email:	
Best time to reach you:			
☐ Address:	State:	☐ Address:	State:
	ZIP Code:		ZIP Code:

II. DEPLOYMENT INFORMATION *(DEP)*

1. Total number of deployments in the PAST 5 YEARS:

☐ I have never deployed *(Skip to 4)*
☐ 0 *(Skip to 4)*
☐ 1
☐ 2
☐ 3
☐ 4
☐ 5 or more

2. Primary country of last deployment:

3. Date departed theater / deployment location: *(dd/mmm/yyyy):*

4. Are you going to deploy within the NEXT 120 DAYS?

☐ Yes
☐ No

III. OCCUPATIONAL INFORMATION *(OCC)*

1. What is your military occupational code *(for example: MOS, AOC, AFSC, NEC, or Designator Code)*?

2. Describe your typical military job duties *(for example: driving a truck, fueling machinery, lifting heavy equipment, working on a computer)*.

3. Does your military specialty require an operational duty physical exam *(e.g., flight, jump, dive, missile, submarine, personnel reliability program, Special Forces)?*

☐ Yes
☐ No

4. Are you currently enrolled in a medical surveillance/occupational health program *(or example: hearing conservation, radiation health, healthcare worker monitoring, etc.)?*

☐ Yes
☐ No
☐ Don't Know

IV. MEDICAL CONDITIONS *(DLMC)*

1. Since your last health assessment, have you experienced any of the following health conditions, and if so what is your status?

HEALTH CONDITION	NO / Does not apply to me	YES, but did NOT get medical care	YES, got medical care, but NO LONGER under treatment /follow-up	YES, and NOW under treatment / follow up
Chest pain *(angina)*	☐	☐	☐	☐
Congestive Heart Failure	☐	☐	☐	☐
Abnormal heart beat *(arrhythmia)*	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Asthma	☐	☐	☐	☐
Other lung problems *(for example: Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, pneumonia, emphysema)*	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐
Cancer or history of cancer	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Change in your vision	☐	☐	☐	☐
Head injury/concussion/Traumatic Brain Injury *(TBI)*	☐	☐	☐	☐
Periods of dizziness, fainting, or loss of consciousness	☐	☐	☐	☐
Neurological problems *(for example: stroke, seizures)*	☐	☐	☐	☐
Persistent or recurring noises in your head or ears *(for example: ringing, buzzing, humming)*	☐	☐	☐	☐
Change in your hearing that impacts duty performance	☐	☐	☐	☐
High or bad cholesterol	☐	☐	☐	☐

2. Since your last PHA, have you experienced any of the following health conditions that either required medical care or impacted your duty performance *(or both)* and if so, what is your status?

HEALTH CONDITION	NO / Does not apply to me	YES, impacted duty performance, but did NOT get medical care	YES, got medical care but NO longer under treatment / follow up	YES, and NOW under treatment / follow up
Wheezing, shortness of breath, or difficulty breathing *(other than asthma)*	☐	☐	☐	☐
New skin condition	☐	☐	☐	☐
Recurring muscle, joint, or low back pain	☐	☐	☐	☐
Recurring headaches/migraines	☐	☐	☐	☐
Stomach problems *(for example: ulcer, reflux)*	☐	☐	☐	☐
Kidney problems *(for example: stones, infection)*	☐	☐	☐	☐
Liver problems *(for example: hepatitis, cirrhosis)*	☐	☐	☐	☐
Blood problems *(for example: hemophilia, sickle cell disease)*	☐	☐	☐	☐
Immune system problems *(for example: HIV, chemotherapy, radiation)*	☐	☐	☐	☐
Tooth or gum problems/pain	☐	☐	☐	☐

3. For each condition, are you currently on any profile or limited duty *(LIMDU)* for that condition?

HEALTH CONDITION	NO	YES
Chest pain *(angina)*	☐	☐
Congestive Heart Failure	☐	☐
Abnormal heart beat *(arrhythmia)*	☐	☐
High blood pressure	☐	☐
Asthma	☐	☐
Wheezing, shortness of breath, or difficulty breathing *(other than asthma)*	☐	☐
Other lung problems *(for example: Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, pneumonia, emphysema)*	☐	☐
Tuberculosis	☐	☐
Cancer or history of cancer	☐	☐
New skin condition	☐	☐
Diabetes	☐	☐
Recurring muscle, joint, or low back pain	☐	☐
Change in your vision	☐	☐
Recurring headaches/migraines	☐	☐
Head injury/concussion/Traumatic Brain Injury *(TBI)*	☐	☐
Periods of dizziness, fainting, or loss of consciousness	☐	☐
Neurological problems *(for example: stroke, seizures)*	☐	☐
Persistent or recurring noises in your head or ears *(for example: ringing, buzzing, humming)*	☐	☐
Change in your hearing that impacts duty performance	☐	☐
High or bad cholesterol	☐	☐
Stomach problems *(for example: ulcer, reflux)*	☐	☐
Kidney problems *(for example: stones, infection)*	☐	☐
Liver problems *(for example: hepatitis, cirrhosis)*	☐	☐
Blood problems *(for example: hemophilia, sickle cell disease)*	☐	☐
Immune system problems *(for example: HIV, chemotherapy, radiation)*	☐	☐
Tooth or gum problems/pain	☐	☐

4. Have you been based or stationed at a location where an open burn pit was used?

- ☐ Yes
- ☐ No
- ☐ Not sure

5. Have you been exposed to toxic airborne chemicals or other airborne contaminants?

- ☐ Yes
- ☐ No *(Skip to 8)*
- ☐ Not sure

6. (If "Yes" or "Not Sure" marked in 4 or 5) Are you enrolled in the Airborne Hazards and Open Burn Pit Registry?

- ☐ Yes *(Skip to 8)*
- ☐ No *(Continue)*

7. If you are eligible, do you elect to enroll in the Airborne Hazards and Open Burn Pit Registry?

- ☐ Yes
- ☐ No/Not eligible

8. Have you had any surgery since your last PHA?

- ☐ Yes *(Continue)*
- ☐ No *(Skip to 10.a.)*

9. What was the condition(s) for which you had surgery and the type of surgery?	
9.a. Condition:	9.a.1. Type of Surgery:
9.b. Condition:	9.b.1. Type of Surgery:
9.c. Condition:	9.c.1. Type of Surgery:

10.a. Since your last PHA, has a health care provider recommended surgery(s) that you have not had *(whether you are planning to have it or not)*?

- ☐ Yes *(Continue)*
- ☐ No *(Skip to 11.a.)*

10.b. For what condition(s) was surgery recommended? *(List)*:

11.a. Do you currently require hearing aids, special medical supplies, CPAP, adaptive equipment, assistive technology devices, and/or other special accommodations?

- ☐ Yes *(Continue)*
- ☐ No *(Skip to 12.a.)*

11.b. What is your requirement(s)? (List):

12.a. Do you currently have a waiver or profile for any part of your Service's physical fitness test? (Skip if Coast Guard or Other)

- ☐ Yes *(Continue)*
- ☐ No *(Skip to 13.a.)*

12.b. Which component(s) of your physical fitness test are waived/profiled? *Mark all that apply.*

- ☐ Body Composition Analysis *(BCA)* / Abdominal Circumference *(not Army)*
- ☐ Cardio Event *(for example: walk, run, bike, elliptical, swim)*
- ☐ Crunches / Sit-Ups
- ☐ *(not Marine Corps)* Push-Ups
- ☐ *(Marine Corps only)* Pull-Ups or Flexed Arm Hang
- ☐ Other:

13.a. Do you have any problems wearing a gas mask, ballistic helmet, body armor, and/or chemical/biological protective garments?

- ☐ Yes *(Continue)*
- ☐ No *(Skip to 14.a.)*
- ☐ Never had to wear these items *(Skip to 14.a.)*

13.b. Please comment on these problems:

14.a. Have you ever been told by a health care provider that you SHOULD NOT receive a vaccine/immunization for medical reasons?

- ☐ Yes *(Continue)*
- ☐ No *(Skip to 15.a.)*

14.b. Which vaccines/immunizations have you been told you should NOT receive? *(List)*:

14.c. Why? *(for example: pregnancy, illness, previous reaction)*

14.d. What was the reaction, if any?

15.a. Are you CURRENTLY on a permanent profile, permanent limited duty *(PLD)*, waiting on a MOS/Medical Retention Board *(MMRB)* decision, or being referred to a Medical Evaluation Board *(MEB)*, or Physical Evaluation Board *(PEB) (Army, Navy, Marine Corps, Coast Guard)* or Do you CURRENTLY have an Assignment Limitation Code C *(Air Force)*?

- ☐ Yes *(Continue)*
- ☐ No *(Skip to 16.a.)*
- ☐ Don't know *(Skip to 16.a.)*

15.b. Why are you currently on a permanent profile *(Army)* or an Assignment Limitation Code C *(Air Force)* or Permanent Limited Duty *(PLD) (Navy, Marine Corps)*? Why are you being referred to a Medical Evaluation Board *(MEB)* and/or Physical Evaluation Board *(PEB) (Coast Guard)*? (Comments):

16.a. Are you on a temporary profile or temporary limited duty *(LIMDU/TLD)*?

- ☐ Yes *(Continue)*
- ☐ Yes, but I feel ready to be evaluated for return to full duty *(Continue)*
- ☐ No *(Skip to 17)*

16.b. Why are you on a temporary profile or temporary limited duty *(LIMDU/TLD)*? *(Comments)*:

17. During the PAST 2 YEARS, how many times have you been placed on a temporary profile or on temporary limited duty *(LIMDU/TLD)*? _____

V. INDIVIDUAL MEDICAL READINESS (IMR)

1. Do you have any allergies *(not including seasonal or pet allergies)*?

- ☐ Yes *(Continue)*
- ☐ No *(Skip to 3)*
- ☐ Don't Know *(Skip to 3)*

2. What are your allergies? *Mark all that apply.*

☐ Adhesive Tape	☐ Iodine	☐ Penicillin
☐ Aspirin	☐ Latex	☐ Shellfish
☐ Bee Stings	☐ Milk	☐ Sulfa Drugs
☐ Codeine	☐ Nickel	☐ Vaccines
☐ Eggs	☐ Nuts	☐ Other: _____

3. Do you have red medical warning "dog tags," and are they current? Some examples of what may require a red dog tag: Allergies to antibiotics and/or other medications/immunizations, diabetes, special medication requirements, sensitivity to bug bites, and sickle cell disease.

- ☐ Yes, I have them and they are current
- ☐ Yes, I have them, but they are not current
- ☐ No, I do not have them, but I require them
- ☐ No, I do not need them

4. Do you wear corrective lenses (*glasses or contacts*)?

- ☐ Yes *(Continue)*
- ☐ No *(Skip to BEHAVIORAL HEALTH)*

5. How many pairs of serviceable glasses do you have with a current prescription *(verified within last 2 years)*?

- ☐ 0
- ☐ 1
- ☐ 2 or more

6. Do you have gas mask inserts with a current prescription *(verified within last 2 years)*?

☐ Yes

☐ No

VI. BEHAVIORAL HEALTH *(MHA)*

1.a. Over the PAST MONTH, which major life stressors, if any, have you experienced that are a cause of significant concern or make it difficult for you to do your work, take care of things at home, or get along with other people? *Mark all that apply.* ☐ None *(Skip to 2.a)*

☐ Legal ☐ Financial ☐ Spiritual ☐ Substance abuse *(including alcohol)* ☐ Family/Relationship

☐ Employment ☐ Sleep ☐ Behavioral Health ☐ Other, explain:

1.b. Are you currently in treatment or getting professional help for these concerns? ☐ Yes ☐ No

2.a. In the PAST YEAR did you receive care for any mental health condition or concern such as, but not limited to, post-traumatic stress disorder *(PTSD)*, depression, anxiety disorder, alcohol abuse, or substance abuse? ☐ Yes ☐ No

2.b. If yes, please explain:

3. What prescription or over-the-counter medications *(including herbals/supplements)* for sleep, pain, combat stress, or a mental health concern are you CURRENTLY taking?

☐ None ☐ Please list

4.a. In the past 12 months, have you gambled?

☐ Yes *(Continue)* ☐ No *(Skip to 5)*

4.b. During the past 12 months, have you become restless, irritable, or anxious when trying to stop/cut down on gambling?

☐ Yes ☐ No

4.c. During the past 12 months, have you tried to keep your family or friends from knowing how much you gambled?

☐ Yes ☐ No

4.d. During the past 12 months, did you have such financial trouble as a result of your gambling that you had to get help with living expenses from family, friends, or welfare?

☐ Yes ☐ No

5.a. How often do you have a drink containing alcohol?

☐ Never *(Skip to 6)* ☐ Monthly or less ☐ 2 - 4 times a month ☐ 2 - 3 times a week ☐ 4 or more times a week

5.b. How many drinks containing alcohol do you have on a typical day when you are drinking?

☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more

5.c. How often do you have six or more drinks on one occasion?

☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

6. Have you ever had any experience that was so frightening, horrible, or upsetting that, in the PAST MONTH, you:

6.a. Have had nightmares about it or thought about it when you did not want to? ☐ Yes ☐ No

6.b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? ☐ Yes ☐ No

6.c. Were constantly on guard, watchful, or easily startled? ☐ Yes ☐ No

6.d. Felt numb or detached from others, activities, or your surroundings? ☐ Yes ☐ No

6.e. Felt guilt or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused? ☐ Yes ☐ No

(NOTE: If three or more items on 6.a. through 6.e. are marked YES, continue to answer items** 6.f. through 6.w.**)

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each question carefully and check the box for how much you have been bothered by that problem in the LAST MONTH. Please answer all items.

	Not at All	A Little Bit	Moderately	Quite a Bit	Extremely
6.f. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	☐	☐	☐	☐	☐
6.g. Repeated, disturbing dreams of a stressful experience from the past?	☐	☐	☐	☐	☐
6.h. Suddenly acting or feeling as if a stressful experience were happening again *(as if you were reliving it)*?	☐	☐	☐	☐	☐
6.i. Feeling very upset when something reminded you of a stressful experience from the past?	☐	☐	☐	☐	☐
6.j. Having physical reactions *(e.g., heart pounding, trouble breathing, or sweating)* when something reminded you of a stressful experience from the past?	☐	☐	☐	☐	☐
6.k. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	☐	☐	☐	☐	☐
6.l. Avoid activities or situations because they remind you of a stressful experience from the past?	☐	☐	☐	☐	☐
6.m. Trouble remembering important parts of a stressful experience from the past?	☐	☐	☐	☐	☐
6.n. Loss of interest in things that you used to enjoy?	☐	☐	☐	☐	☐
6.o. Feeling distant or cut off from other people?	☐	☐	☐	☐	☐
6.p. Feeling emotionally numb or being unable to have loving feelings for those close to you?	☐	☐	☐	☐	☐
6.q. Feeling as if your future will somehow be cut short?	☐	☐	☐	☐	☐
6.r. Trouble falling or staying asleep?	☐	☐	☐	☐	☐
6.s. Feeling irritable or having angry outbursts?	☐	☐	☐	☐	☐
6.t. Having difficulty concentrating?	☐	☐	☐	☐	☐
6.u. Being “super alert” or watchful, on guard?	☐	☐	☐	☐	☐
6.v. Feeling jumpy or easily startled?	☐	☐	☐	☐	☐

	Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
6.w. How difficult have these problems *(6.f. through 6.v.)* made it for you to do your work, take care of things at home, or get along with other people?	☐	☐	☐	☐

7. Over the LAST 2 WEEKS, how often have you been bothered by the following problems?

	Not at All	Few or Several Days	More Than Half the Days	Nearly Every Day
7.a. Little interest or pleasure in doing things	☐	☐	☐	☐
7.b. Feeling down, depressed, or hopeless	☐	☐	☐	☐

(NOTE: If** 7.a. or 7.b. **are marked "More than half the days" or "Nearly every day," continue to answer items 7.c. through 7.i.)

	Not at All	Few or Several Days	More Than Half the Days	Nearly Every Day
7.c. Trouble falling/staying asleep, sleep too much.	☐	☐	☐	☐
7.d. Feeling tired or having little energy.	☐	☐	☐	☐
7.e. Poor appetite or overeating.	☐	☐	☐	☐
7.f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
7.g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
7.h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety that you have been moving around a lot more than usual.	☐	☐	☐	☐
	Not Difficult at All	**Somewhat Difficult**	**Very Difficult**	**Extremely Difficult**
7.i. How difficult have these problems *(7.a. through 7.h.)* made it for you to do your work, take care of things at home, or get along with other people?	☐	☐	☐	☐

8. Would you like to schedule an appointment with a health care provider to discuss any health concerns? ☐ Yes ☐ No

9. Are you interested in receiving information or assistance for a stress, emotional, or alcohol concern? ☐ Yes ☐ No

10. Are you interested in receiving assistance for a family or relationship concern? ☐ Yes ☐ No

11. Would you like to schedule a visit with a chaplain, mental health care provider, or a community support counselor? ☐ Yes ☐ No

VII. FAMILY HISTORY AND LIFESTYLE *(LIF)*

1. Overall, how would you rate your health during the PAST MONTH?

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. To the best of your knowledge, do or did any of the following blood relatives – parents, grandparents, brothers, or sisters – ever have any of the following medical problems? *Mark all that apply.*

☐ Cancer or malignancy of any kind

☐ Heart-related conditions such as high blood pressure, heart attack, coronary heart disease, cardiac arrhythmia *(irregular heartbeat)*, or sudden death

☐ Diabetes

☐ No/Don't Know *(Skip to 6)*

3. *(If Cancer marked in 2)* Which of the following family members has/had the history of cancer? *Mark all that apply.*

FAMILY HISTORY OF CANCER	Mother	Father	Any Grandmother	Any Grandfather	Any Brother	Any Sister
Breast	☐	☐	☐	☐	☐	☐
Colon	☐	☐	☐	☐	☐	☐
Ovarian	☐	☐	☐	☐	☐	☐
Prostate	☐	☐	☐	☐	☐	☐
Other *(List)*: _____	☐	☐	☐	☐	☐	☐
Other *(List)*: _____	☐	☐	☐	☐	☐	☐
Other *(List)*: _____	☐	☐	☐	☐	☐	☐
Unknown Type of Cancer	☐	☐	☐	☐	☐	☐

4. *(If heart-related conditions marked in 2)* Which of the following family members has/had the history of heart-related conditions? *Mark all that apply.*

FAMILY HISTORY OF HEART-RELATED CONDITIONS	Mother	Father	Any Grandmother	Any Grandfather	Any Brother	Any Sister
High Blood Pressure	☐	☐	☐	☐	☐	☐
Heart Attack/Coronary Artery Disease	☐	☐	☐	☐	☐	☐
Cardiac Arrhythmia/Irregular Heartbeat	☐	☐	☐	☐	☐	☐
Sudden Cardiac Death	☐	☐	☐	☐	☐	☐
Other *(List)*: _____	☐	☐	☐	☐	☐	☐
Other *(List)*: _____	☐	☐	☐	☐	☐	☐
Other *(List)*: _____	☐	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐	☐

5. *(If Diabetes marked in 2)* Which of the following family members has/had the history of diabetes? *Mark all that apply.*

FAMILY HISTORY OF DIABETES	Mother	Father	Any Grandmother	Any Grandfather	Any Brother	Any Sister
Type I *(body is unable to produce insulin; usually develops before the age of 40)*	☐	☐	☐	☐	☐	☐
Type II *(a chronic condition that affects the way the body processes blood sugar (glucose); usually appears later in life)*	☐	☐	☐	☐	☐	☐
Unknown	☐	☐	☐	☐	☐	☐

6. I participate in moderate intensity physical activities at least 2 ½ hours, or a combination of moderate and vigorous aerobic activities, for at least 75 minutes per week. ☐ Yes ☐ No

7. In a typical week, I do physical activities specifically designed to STRENGTHEN my muscles such as lifting weights or doing calisthenics:
_____ Day(s) per week

8. What prescriptions or over-the-counter medications *(including Tylenol, Advil, Sudafed, and/or aspirin)* are you CURRENTLY taking for health problems on a ROUTINE BASIS? Do NOT include vitamins or nutritional supplements.
☐ None *(List Medications)*:
☐ Medications

9. Which of the following products, or products marketed for the following purposes, have you taken, even once, since your last PHA?
☐ Protein Supplements/Creatine *(such as products that may contain individual or blends of amino acids like leucine, arginine, glutamine, beta-alanine, BCAA, casein, soy, whey, or plant-based protein powders/shakes; or creatine alone)*
☐ Muscle Building/Testosterone Boosting Products *(such as products that may contain pro-hormones, hormone boosters, hormone support, "legal steroids", "anabolic", deer velvet, "Andro", anti-estrogen, estrogen blocker, DHEA, 7-Keto, IGF-1, growth hormone, Hydroxymethylbutyrate/HMB, or insulin releasing (factors))*
☐ Performance Enhancers/Pre-Workout Products *(such as C4, Nitric Oxide, Mr. Hyde, Synephrine/Citrus Aurantium, bitter orange, Yohimbe/ Yohimbine, or ephedra-free stimulants)*
☐ Energy Shots, NOT including energy drinks
☐ Weight Loss Products *(such as Hydroxycut, Dexatrim, Metabolife, QuickTrim, Xenadrine, Garcinia Cambogia, green coffee bean extract, or products using marketing terms or phrases like "Ripped", "Lipo", "Heat", "Cut", or "Shred")*
☐ Herbal or Botanical Supplements in pills, gels, and/or tablet form *(such as St. John's Wort, Ginkgo, Echinacea, Ginseng, Saw Palmetto, Black Cohosh, Curcumin, cinnamon, ginger, or clove)*
☐ Multi-Vitamins *(such as Centrum or One-A-Day)*
☐ Individual Vitamins or Minerals *(such as calcium, iron, selenium, vitamin C)*
☐ Omega-3 Supplements *(oil such as fish, krill, cod liver, or flaxseed)*
☐ Vitamin D
☐ Joint Care Supplements *(orally consumed products to relieve/prevent joint pain or improve joint function such as glucosamine, chondroitin, or MSM)*
☐ None of the above *(Skip to 11)*

NOTE: Supplements, ingredients, and terms listed in parentheses are examples only, and not meant to imply they are the only possible choices in the category.

10. *(For items marked in 9)* Since your last PHA, how often did you take:

	Less Than Once a Month	Once a Month	Once a Week	Every Other Day	Once a Day	Two or More Times a Day
Protein Supplements/Creatine	☐	☐	☐	☐	☐	☐
Muscle Building Products	☐	☐	☐	☐	☐	☐
Performance Enhancers	☐	☐	☐	☐	☐	☐
Energy Shots, NOT including energy drinks	☐	☐	☐	☐	☐	☐
Weight Loss Products	☐	☐	☐	☐	☐	☐
Herbal or Botanical Supplements in pills, gels, and/or tablet form	☐	☐	☐	☐	☐	☐
Multi-Vitamins	☐	☐	☐	☐	☐	☐
Individual Vitamins or Minerals	☐	☐	☐	☐	☐	☐
Omega-3 Supplements	☐	☐	☐	☐	☐	☐
Vitamin D	☐	☐	☐	☐	☐	☐
Joint Care Supplements	☐	☐	☐	☐	☐	☐

11. Think about the PAST 30 DAYS. How often did you eat/drink the following foods/beverages?

TYPE OF FOOD/BEVERAGE	Rarely or Never	1 or 2 Servings per Week	3 to 6 Servings per Week	1 Serving per Day	2 Servings per Day	3 or More Servings per Day
Fruits *(These include fresh, frozen, canned, dried, and 100% fruit juices. A serving is 1 cup of fruit or 1 medium size piece of fruit or ½ cup of fruit juice or ½ cup dried fruit)*	☐	☐	☐	☐	☐	☐
Vegetables *(Examples include fresh, frozen, canned, cooked, or raw: dark green vegetables (broccoli, spinach, most greens), orange vegetables (carrots, sweet potatoes, winter squash, pumpkin), legumes (dry beans, chickpeas, tofu), and others (tomatoes, cabbage, celery, cucumber, lettuce, onions, peppers, green beans, cauliflower, mushrooms, summer squash). A serving is 1 cup of raw vegetables or ½ cup of cooked vegetables)*	☐	☐	☐	☐	☐	☐
Starchy Vegetables *(These include beans (kidney, navy, pinto, black, cannellini), corn, green peas, lentils, parsnips, plantains, potatoes, pumpkins, and squash (acorn, butternut). A serving is ½ cup of cooked vegetables.)*	☐	☐	☐	☐	☐	☐
Whole Grains *(These include rye, whole wheat, or heavily seeded bread; brown or wild rice; whole wheat pasta or crackers; oatmeal; or corn tacos. A serving is 1 slice of bread, or ½ cup of grains.)*	☐	☐	☐	☐	☐	☐
Dairy and Calcium Containing Foods *(Examples include milk (2%, 1%, ½%, skim); yogurt; cottage cheese; low-fat cheese; frozen yogurt; or other calcium fortified foods (orange juice, soy/rice milk, breakfast cereals). A serving is 8 ounces of liquid or 1 ounce of cheese.)*	☐	☐	☐	☐	☐	☐
Fish *(Examples include tuna, salmon, or other non-fried fish. A serving is 3.5 ounces or ¾ cup.)*	☐	☐	☐	☐	☐	☐
Lean Protein *(White meat from chicken/turkey)*	☐	☐	☐	☐	☐	☐
Sugar-Sweetened Beverages *(These contain caloric sweeteners and include soft drinks, fruit drinks (such as Kool-Aid, or lemonade), sweet tea, coffee/tea drinks, and sports or energy drinks (such as Gatorade or Red Bull). 1 serving is 8-12 ounces.)*	☐	☐	☐	☐	☐	☐

12. *(If Traditional Guardsman or Drilling Reservist (TPU/IMA), Individual Ready Reserve (IRR), or Inactive National Guard (ING))* Have you had a cholesterol check by a doctor, nurse, or other health care professional within the PAST 5 YEARS?

- ☐ Yes
- ☐ No
- ☐ Don't Know

This form must be completed electronically. Handwritten forms will not be accepted.

13.a. In the PAST 30 DAYS, which of the following products have you used on at least one day? *Mark all that apply.*

- ☐ Cigarettes *(If marked, SM must complete 13.d.)*
- ☐ Cigars, Cigarillos, or Little Cigars
- ☐ Chewing Tobacco, Snuff, or Dip
- ☐ Electronic Cigarettes, E-Cigarettes, or Vape Pens
- ☐ Hookahs or Waterpipes
- ☐ Pipes filled with tobacco *(not Waterpipes)*
- ☐ Snus *(moist tobacco powder placed under the lip)*
- ☐ Dissolvable Tobacco Products
- ☐ Bidis *(small brown cigarettes wrapped in a leaf)*
- ☐ Other: _____
- ☐ None *(Skip to 15)*

13.b. How long have you been using tobacco products?

☐ < 1 year ☐ 1 to 5 years ☐ 6 to 10 years ☐ 11 to 15 years ☐ > 15 years

13.c. How often do you smoke tobacco *(for example cigarettes, cigars, pipes, or hookah)*?

☐ Just about every day ☐ Some days

13.d. *(For individuals who smoke cigarettes)* How many packs per day do you smoke?

☐ < ½ pack/day ☐ ½ to 1 pack/day ☐ 1 ½ to 2 packs/day ☐ 2 ½ to 3 packs/day ☐ > 3 packs/day

14. Are you interested in quitting tobacco?

☐ Yes, I would like a referral *(Skip to 16)* ☐ Yes, but I do not want a referral *(Skip to 16)* ☐ No *(Skip to 16)*

15. Which of the following best describes your past tobacco use?

☐ I used tobacco in the past, but quit in _____ *(year)* ☐ I have never used tobacco products

16. Are you regularly exposed to secondhand smoke, a mixture of smoke that comes from the burning end of a cigarette, cigar, or pipe, and the smoke breathed out by the smoker *(housemate, carpool, work environment)*?

☐ Yes ☐ No

17. During the LAST 2 WEEKS, how many hours of sleep did you get on most days?

- ☐ Less than 5 hours
- ☐ 5 to less than 7 hours
- ☐ 7 to 9 hours
- ☐ More than 9 hours

18. During the LAST 2 WEEKS, have you felt impaired or unable to adequately perform due to sleepiness or poor quality sleep?

☐ Yes ☐ No

19. Have you had any unexplained weight loss or gain since your last PHA?

☐ Yes ☐ No

20. Sexually transmitted infections or diseases *(STIs/STDs)* are common. Risk factors for these include, but are not limited to *(choose an answer based on your risk)*:

1. A new sex partner in the past 3 months
2. More than one sex partner in the last 12 months
3. Sexually active women less than 25 years of age
4. Inconsistent use of latex condoms *(not using latex condoms every time)*
5. Men who have sex with men
6. Sexual contact with person(s) with known STIs/STDs or known risk of STIs/STDs
7. Exchanged money or drugs for sex
8. Injection drug use

- ☐ At least one of the risk factors listed applies to me
- ☐ The risk factors listed do NOT apply to me

21. *(For males who identify "At least one of the risk factors listed applies to me" question 20)* Have you had a syphilis, chlamydia, and gonorrhea test since your last PHA?

☐ Yes ☐ No

22. Since your last PHA, what contraceptive methods, if any, have you and your partner(s) been using to prevent pregnancy? *Mark all that apply.*

I am not actively taking steps to prevent pregnancy as:

- ☐ I am, or my partner is, currently pregnant
- ☐ My partner(s) or I intend to get pregnant in the next year
- ☐ I have a same sex partner(s)
- ☐ I am not sexually active
- ☐ My partner(s) or I do not use any contraception

I am actively taking steps to prevent pregnancy, including:

- ☐ Sterilization *(for example: vasectomy, tubal sterilization, trans-cervical sterilization, hysterectomy)*
- ☐ Long Term - IUD *(including copper or progesterone)* or implant
- ☐ Injectable – Every 3 months
- ☐ Daily - Birth control pills
- ☐ Monthly - Contraceptive patch/vaginal ring
- ☐ Emergency contraception *(such as Plan B)*
- ☐ Other contraceptive method, please describe: _____

With intercourse *(mark all that apply)*:

- ☐ Condoms
- ☐ Withdrawal or "pulling out"
- ☐ Rhythm by calendar/temperature/cervical mucus test
- ☐ Cervical cap/diaphragm

23. In the last year, have you or your partner had a pregnancy scare, where you were not trying to get pregnant but were worried enough to use a home pregnancy test?

☐ Yes ☐ No

VIII. WOMEN'S HEALTH *(FEMALE SERVICE MEMBERS ONLY) (WOM)*

1. Do you wish to receive contraceptive counseling?

☐ Yes ☐ No

2. Which of the following best describes you?

- ☐ I am or may be pregnant *(Skip to 5)*
- ☐ I was pregnant or just delivered within the past 6 months *(Continue)*
- ☐ I was pregnant or delivered 6 – 12 months ago *(Continue)*
- ☐ I am not pregnant now, and was not pregnant or delivered in the past 12 months *(Continue)*

3. Have you had a total hysterectomy *(uterus and cervix removed)*?

☐ Yes *(Skip to 7)* ☐ No *(Continue)*

4. Are you postmenopausal and no longer experiencing menstrual cycles?

☐ Yes *(Skip to 7)* ☐ No *(Continue)*

5. Are you currently taking folic acid or a vitamin containing folic acid?

- ☐ Yes
- ☐ No
- ☐ Don't Know

6. Do you have heavy and/or irregular menstrual cycles/pain or premenstrual syndrome *(PMS)*?

- ☐ Yes, but I am in treatment and having no problems
- ☐ Yes, and I am having ongoing issues
- ☐ No

7. Do you have recurrent urinary tract infections *(more than 3 in the past 12 months)*?

- ☐ Yes, but I am in treatment and having no problems
- ☐ Yes, and I am having ongoing issues
- ☐ No

8. *(If Question 3 is "No" or "Blank")* Have you had a Pap test *(cervical cancer screening)* within the PAST 3 YEARS?

- ☐ Yes
- ☐ No
- ☐ Don't Know

9. Have you ever had an abnormal Pap Test?

- ☐ Yes *(continue)*
- ☐ No *(skip to 11)*
- ☐ Don't Know *(continue)*

10. Have you ever had a colposcopy *(test to better look at cervix)*, excisional procedure *(known as LEEP or Cold Knife Cone)*, or cryotherapy *(freezing)* on your cervix?

- ☐ Yes
- ☐ No
- ☐ Don't Know

11. *(If age 50 or older)* Have you had a mammogram within the PAST 24 MONTHS?

- ☐ Yes
- ☐ No

12. *(If pregnant or may be pregnant (Question 2) and/or "At least one of the risk factors listed applies to me" (Question LIF20))* Have you had a syphilis, chlamydia and gonorrhea test since your last PHA?

- ☐ Yes
- ☐ No

13. Do you have a history of gestational diabetes?

- ☐ Yes
- ☐ No

IX. RESERVE COMPONENT *(TRADITIONAL GUARDSMEN, DRILLING RESERVISTS (TPU,IMA), INDIVIDUAL READY RESERVE (IRR), INACTIVE NATIONAL GUARD (ING) ONLY, NOT AGR/FTS) (RES)*

(Questions are for Traditional Guardsmen and Drilling Reservists, Individual Ready Reserve, and Inactive National Guard. All others skip to OTHER MEDICAL)

1. Do you have an injury, illness, or disease which was incurred or aggravated while in a duty status since your last PHA?

☐ Yes *(Continue)* ☐ No *(Skip to 4)*

2. Have you completed or are you pending a Line of Duty *(LOD)* for that injury, illness, or disease to receive healthcare within the Military Health System *(MTF or TRICARE referral from Defense Health Agency Great Lakes)* or the VA?

- ☐ Yes, I have an initiated LOD or it is pending
- ☐ Yes, I have a completed LOD
- ☐ No

3. What is your injury, illness, or disease? When did it occur?

Injury/Illness/Disease *(1)*: Date *(mmm/yyyy)*:

Injury/Illness/Disease *(2)*: Date *(mmm/yyyy)*:

Injury/Illness/Disease *(3)*: Date *(mmm/yyyy)*:

4. Are you currently covered under a health insurance policy? *Mark all that apply.*

☐ Yes -- TRICARE ☐ Yes -- Other health insurance ☐ No

5.a. Do you have any current physical or mental health limitations related to a Workers' Compensation claim *(regardless of whether the claim was approved)*?

- ☐ Yes *(if yes, list limitations)*
- ☐ No, I have never applied for Worker's Compensation
- ☐ No, I applied for Worker's Compensation, but have no limitations

5.b. List Limitations:

6. Have you applied for, or have you received a VA disability rating?

- ☐ No *(Skip to OTHER MEDICAL)*
- ☐ Yes, I received a VA disability rating *(Continue)*
- ☐ Yes, my application is pending *(Skip to 9)*
- ☐ Yes, I applied, but my claim was denied *(Skip to 9)*

7. What is your total disability rating *(%)*?

8. What is the approximate date you received your disability rating *(mmm/yyyy)*?

9. What type of injury(s) or medical condition(s) is the basis of your VA disability claim(s)?

10. List any physical or mental health limitations you have related to your VA disability injury(s)/condition(s):

X. OTHER MEDICAL *(OTH)*

1. *(PAIN SCALE)* Rate the amount of pain you have had, on average, over the PAST 24 HOURS.

- ☐ 0 = No pain *(Skip to 3)*
- ☐ 1 = Hardly notice pain *(Continue)*
- ☐ 2 = Notice pain, does not interfere with activities *(Continue)*
- ☐ 3 = Sometimes distracts me *(Continue)*
- ☐ 4 = Distracts me, can do usual activities *(Continue)*
- ☐ 5 = Interrupts some activities *(Continue)*
- ☐ 6 = Hard to ignore, avoid usual activities *(Continue)*
- ☐ 7 = Focus of attention, prevents doing daily activities *(Continue)*
- ☐ 8 = Awful, hard to do anything *(Continue)*
- ☐ 9 = Can't bear the pain, unable to do anything *(Continue)*
- ☐ 10 = As bad as it could be, nothing else matters *(Continue)*

2. Are you receiving treatment for pain?

☐ Yes ☐ No

3. Since your last PHA, have you received care or treatment for any medical and/or mental health condition(s) from a CIVILIAN or NON-MILITARY facility? This includes privately paid elective surgeries.

☐ Yes *(Continue)* ☐ No *(Skip to 5)*

4. List the condition(s) treated and where the care was provided.

(List Conditions): *(Where care was provided)*:

5. I acknowledge I am responsible to report medical *(including mental health)* and health issues that may affect my readiness to deploy or fitness to continue serving in an active status in accordance with Department of Defense Instruction 6025.19, Individual Medical Readiness. As a condition of continued participation in military service, I must report significant health information to my chain of command. In addition, I will authorize and facilitate disclosures of all health information by any non-DoD health care provider(s) to the Military Health System (*MHS*) and/or to my respective Reserve Component.

☐ I Acknowledge

6. Are you concerned about any other health condition(s) or health risk exposures not already addressed?

- ☐ Yes, please explain:
- ☐ None

7. Would you like to schedule an appointment with a health care provider to discuss any health concerns?

☐ Yes ☐ No

XI. SEPARATION AND RETIREMENT *(SEP)*

1. Are you planning to separate or retire within the next year from Active Duty or Reserve Duty *(activated for greater than 30 continuous days)* or do you intend to file a claim for disability compensation with the Veterans Benefits Administration?

☐ Yes ☐ No

This form must be completed electronically. Handwritten forms will not be accepted.

PART B. RECORD REVIEW AND RECOMMENDATIONS *(RECORD REVIEWER ONLY)*

I. RECORD REVIEWER INFORMATION

1. Last Name:	2. First Name:	3. Middle Name:

4. Service Branch/Affiliation:

- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ Coast Guard
- ☐ U.S Public Health Service
- ☐ Other *(List):* _____

5. Status:

- ☐ Active Duty
- ☐ Traditional Guardsman
- ☐ Reservist
- ☐ Active Guard Reserve or Full-time Support
- ☐ Air Reserve Technician
- ☐ Civilian Government Employee
- ☐ Contractor
- ☐ Other *(List)*: _____

6. Title:

- ☐ Physician *(MD, DO)*
- ☐ Physician Assistant (*PA*)
- ☐ Nurse Practitioner (*NP*)
- ☐ Advance Practice Nurse (*Clinical Nurse Specialist*)
- ☐ Registered Nurse (*BSN, ADN, Diploma Graduate*)
- ☐ Licensed Vocational Nurse (*LVN, LPN*)
- ☐ Independent Duty Medical Technician
- ☐ Independent Duty Corpsman
- ☐ Independent Duty Health Services Technician
- ☐ Special Forces Medical Sergeant
- ☐ Medic/Corpsman/Medical Technician
- ☐ Public Health Technician
- ☐ Health Services Technician
- ☐ Medical Clerk
- ☐ Other (*List*): _____

7. Email:	8. Facility:		9. Unit:
10. Address:	11. State:	12. ZIP Code:	14. Date Record Review Initiated (*dd/mmm/yyyy*):
	13. Phone (*Commercial*):		

II. MEDICAL SCREENING

1. Date of Service member's most recent PHA (*dd/mmm/yyyy*): ☐ No PHA Documented

2. Service member's most recently documented height:	Feet:	Inches:	Date (*dd/mmm/yyyy*):	☐ No Height Documented
3. Service member's most recently documented weight:		Pounds:	Date (*dd/mmm/yyyy*):	☐ No Weight Documented

4. What is the Service member's most recently documented blood pressure reading?

Date (*dd/mmm/yyyy*): Systolic/Diastolic: ☐ No Blood Pressure Documented

5. Does the Service member have a history of abnormal blood pressure since their last PHA? ☐ Yes ☐ No

6. Does the Service member have a laboratory test of sickle cell trait documented in their permanent medical record? ☐ Yes ☐ No

7. What is the date of the Service member's most recently documented cholesterol test?

Date (*dd/mmm/yyyy*): ☐ No Cholesterol Test Documented

8. (*For individuals >50 years of age*) What is the date of the Service member's most recently documented colon cancer screening?

Date (*dd/mmm/yyyy*): ☐ No Colon Cancer Screening Documented

9. List of Service member's active medications listed in their permanent medical record:

(*List*): ☐ No Active Medications Documented

10. Is there a discrepancy between the active medication record review and the Service member's self-reported list of medications? (*Medications from MHA3 and LIF8*)

☐ Yes ☐ No If "Yes," list discrepancies:

11. List documented significant care the Service member has received since their last PHA from a provider OUTSIDE the Military Health System (*for example a civilian or non-military facility*). This includes privately paid elective surgeries.

List:

☐ No Outside Care Documented

12. Is there a discrepancy between the Service member's list of OUTSIDE care (*from OTH3*), and the OUTSIDE care found in the record (*see 11*)?

☐ Yes ☐ No If "Yes," list discrepancies:

13. List documented significant care the Service member has received since their last PHA from a provider INSIDE the Military Health System.

List:

☐ No Inside Care Documented

14. *(If Service member reported having surgery since their last PHA in DLMC4)* Is there documentation in the record for each surgery listed below?

CONDITION	TYPE OF SURGERY	YES	NO	Record Unavailable
(List 1 from DLMC5):	(*List 1 from DLMC5*):	☐	☐	☐
(List 2 from DLMC5):	(*List 2 from DLMC5*):	☐	☐	☐
(List 3 from DLMC5):	(*List 3 from DLMC5*):	☐	☐	☐

15. (*If Service member answered "Yes" in DLMC10.a.*) Confirm that vaccine exemptions are listed in the medical record and that Service member has documented exemption(s) in the appropriate system of record (*AHLTA, ASIMS, MEDPROS, MRRS, etc.*) for each vaccine listed (*from DMLC10.b.*).

☐ Confirmed All ☐ Not All Confirmed Comments: _____

16. (*If Service member reported allergies in IMR1*) Review available medical documentation and compare with Service member responses. Document any discrepancies.

Service member's reported allergies (*from IMR2*):

☐ Discrepancies with Record Comments (*If "Discrepancies with Record"*):

☐ Not All Confirmed

III. OCCUPATION-SPECIFIC EXAMINATIONS

1. (*If the Service member indicated they are required to have a special operational duty physical exam in OCC3*) When was the Service member's most recently documented special operational duty physical exam (*e.g., flight, jump, dive, missile, submarine, reliability program, Special Forces, etc.*)?

Date (*dd/mmm/yyyy*):

☐ No Documented Exam ☐ Record Unavailable

2. (If the Service member indicated they are enrolled in a medical surveillance/occupational health program in OCC4) When was the Service member's most recently documented evaluation (for example: hearing conservation, radiation health, healthcare worker/hospital employee monitoring, etc.)?

Date (*dd/mmm/yyyy*):

☐ No Documented Evaluation ☐ Record Unavailable

IV. FAMILY HISTORY AND LIFESTYLE

1. Does the DD 2766 reflect the Service member's reported family history (*from LIF2-5*)?

☐ Yes, DD2766 reflects correct family history

☐ No, DD2766 needs to be updated If "No" describe needed update(s):

2. (*For males who identify "At least one of the risk factors listed applies to me" in* (*LIF20*)) Is there a record of the Service member receiving a syphilis, chlamydia and gonorrhea test since their last PHA?

☐ Yes ☐ No

This form must be completed electronically. Handwritten forms will not be accepted.

V. WOMEN'S HEALTH

1. (*If Service member reported she is or may be pregnant OR delivered in past 6 months in WOM2*) The Service member indicated a possible pregnancy, pregnancy, or recent delivery. Does the Service member have an appropriate profile and/or waiver in accordance with Service policy?

☐ Not Applicable, pregnancy not yet confirmed (*Skip to 3*) ☐ No, does not have a profile/waiver (*Skip to 3*) ☐ Yes, has a profile/waiver (*Continue*)

2. Review the appropriate health records associated with this pregnancy and summarize, noting if the Service member has been evaluated for any occupational health concerns.

Notes:

3. (If Service member reported she has not had a total hysterectomy in WOM3) What is the date and result of the Service member's most recent Pap test?

Date (*dd/mmm/yyyy*): ☐ Normal ☐ Abnormal ☐ No Documented Pap Test

4. (*If Service member reported she had an abnormal PAP test in WOM9 or had a colposcopy, excisional procedure, or cryotherapy on her cervix in WOM10*) Review the appropriate health records associated with history of abnormal Pap, colposcopy, excisional procedure, or cryotherapy, and summarize next required follow up.

Notes:

5. (*If Service member is age 50 or greater*) What is the date of the Service member's most recently documented mammogram?

Date (*dd/mmm/yyyy*): ☐ No Documented Mammogram

6. (*If Service member is or may be pregnant* (*WOM2*), *and/or is a female who identifies "At least one of the risk factors listed applies to me"* (*LIF20*))
Is there a record of the Service member receiving a syphilis, chlamydia, and gonorrhea test since her last PHA?

☐ Yes ☐ No

VI. DEPLOYMENT-RELATED HEALTH ASSESSMENTS

1. (*If DEP3 date is within past 3 years*) Based on your check of records, does the Service member have any due or overdue deployment health assessments which need to be completed with this PHA?

☐ Yes ☐ No

2. (*If DEP4 marked "YES"*) Service member indicated a scheduled deployment in the next 120 days. Has the Service member completed the Pre-Deployment Health Assessment (*DD Form 2795*) for their upcoming deployment (*if required*)?

☐ Yes ☐ No

VII. INDIVIDUAL MEDICAL READINESS

Deployment-Limiting Medical & Dental Conditions

1. Is the Service member currently on a profile, limited duty (*LIMDU*), temporary limited duty (*TLD*), waiting on a MOS/Medical Retention Board (*MMRB*) decision, or being referred to a medical evaluation board (*MEB*) or physical evaluation board? (*PEB*), (*if Army, Navy, Marine Corps, Coast Guard*), or Is the Service member currently on an Assignment Limitation Code C (*for Air Force*)?

☐ Yes ☐ No

2. (*If answered "Yes" or "Yes, but" to DLMC12.a.*) How many months in the past year has the Service member been on temporary duty / temporary profile / temporary limited duty (*LIMDU/TLD*) / MEDHOLD / NMA / MRR / LOD status?

Number of Months:	Date Temporary Situation Expires (*dd/mmm/yyyy*):	☐ No Record of Temporary Situation

Dental Assessment

3. When was the Service member's most recently documented dental exam?

Date (*dd/mmm/yyyy*):	Classification: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ No Classification Code Listed	☐ No Dental Exam Documented

Immunizations

4. Is the Service member current on all required immunizations in the immunization tracking system?

☐ Yes ☐ No If "No" List Overdue Immunization(s):

Individual Medical Equipment

5. (*If Service member reported wearing corrective lenses in IMR4*) Is the Service member current with Service-specific requirements for glasses and gas mask inserts?

☐ Yes, Service member is current ☐ No, Service member needs: (*List*):

Medical Readiness & Laboratory Studies

6. Does the Service member have the following laboratory tests documented in their permanent medical record?

TEST TYPE	YES	NO
Human Immunodeficiency Virus (*HIV*) test within the PAST 24 MONTHS	☐	☐
G6PD results on file	☐	☐
Blood type and Rh on file	☐	☐
DNA test on file	☐	☐

VIII. RESERVE COMPONENT (*GUARD AND RESERVE ONLY*)

1. (*If Service member indicated they have a VA disability rating in RES6*) What is the Service member's VA disability rating?

Percent VA Disability Rating (%):

☐ No Documented VA Disability Rating (%)

IX. ADDITIONAL RECORD REVIEWER COMMENTS

1. If the record review indicates the potential need for provider notification or referral, mark below. Consult with a provider as necessary and annotate action(s) taken under "comments" in Question 2. *Mark all that apply*.

☐ Provider Notified ☐ Command Notified ☐ Notification is NOT required

2. Provide any additional comments about this record review that need to be forwarded to the Health Care Professional completing PART C (*Provider Review, Interview, Assessment, and Recommendations*) of this form.

Comments:

☐ No additional comments

X. RECORD REVIEWER DIGITAL SIGNATURE AND COMPLETION DATE

Record Reviewer Digital Signature:	Date Record Review Completed (*dd/mmm/yyyy*):

This form must be completed electronically. Handwritten forms will not be accepted.

PART C. HEALTH CARE PROVIDER (*HCP ONLY*)
(*Provider Review, Interview, Assessment and Recommendations*)

1. Indicate which assessment(s) you are completing:

☐ Both PHA & MHA (*Continue to Section I*) ☐ PHA ONLY (*Skip to Section III*) ☐ MHA ONLY (*Continue to Section I*)

I. MENTAL HEALTH ASSESSMENT (*MHA*) PROVIDER INFORMATION

1. Last Name:	2. First Name:	3. Middle Name:

4. Service Branch:

☐ Air Force
☐ Army
☐ Navy
☐ Marine Corps
☐ Coast Guard
☐ U.S Public Health Service
☐ Other (*e.g., RHRP contractor*)

5. Status:

☐ Active Duty
☐ Traditional Guardsman
☐ Reservist
☐ Active Guard Reserve or Full-time Support
☐ Civilian Government Employee
☐ Civilian Contractor
☐ Other (*List*): _____

6. Select the appropriate title.

☐ Physician (*MD, DO*)
☐ Nurse Practitioner (*NP*)
☐ Physician Assistant (*PA*)
☐ Advance Practice Nurse (*Clinical Nurse Specialist*)
☐ Independent Duty Corpsman
☐ Independent Duty Health Services Technician
☐ Independent Duty Medical Technician
☐ Special Forces Medical Sergeant
☐ Clinical Psychologist
☐ Other Licensed Mental Health Professional

7. Email:	8. Facility:	9. Unit:
10. Address:	11. State: / 12. ZIP Code:	14. Date MHA Provider Review Initiated (*dd/mmm/yyyy*):
	13. Phone (*Commercial*):	

II. MENTAL HEALTH ASSESSMENT (*Corresponds with Service Member Section VI. Behavioral Health* (*MHA*))

Service member reports most recent deployment was to/is to (*Country*): _____, and has deployed: _____ times before in the past five years.

1. Major life stressor as reported on Service member (*MHA1.a.*).

a. Did Service member mark they have a concern or a difficulty with a major life stressor?

☐ Yes ☐ No (*Skip to 2*) ☐ Not answered by Service member If "Yes" list Service members concern(s):

b. If "Yes," ask additional questions to determine level of problem:

c. Consider need for referral. Referral indicated?

☐ Yes (*complete blocks 9 and 10*) ☐ No: ☐ Already under care ☐ Already has a referral ☐ No significant impairment ☐ Other reason (*explain*):

2. Address concerns as reported in Service member questions (*MHA2 and MHA3*).

Service member question	Not answered	Yes response	Service member's response:	Provider comments (*if indicated*):
History of mental health care	☐	☐		
Medications	☐	☐		

3. Alcohol use as reported in Service member question (*MHA5*).

a. Service member's AUDIT-C screening score was: *If score between 0-4 (men), or 0-3 (women) nothing required, go to block 4.* ☐ Not answered by Service member

Number of drinks per week: _____ Maximum number of drinks per occasion: _____

Based on the AUDIT-C score and assessment of alcohol use, follow the guidance below:

Alcohol Use Intervention Matrix

Assess Alcohol Use	AUDIT-C Score Men (*5 – 7*) Women (*4 - 7*)	AUDIT-C Score Men and Women(*> 8*)
Alcohol use WITHIN recommended limits: Men: ≤ 14 drinks per week **OR** ≤ 4 drinks on any occasion Women: ≤ 7 drinks per week **OR** ≤ 3 drinks on any occasion	Advise patient to stay below recommended limits	Refer if indicated for further evaluation AND Conduct BRIEF counseling*
Alcohol use EXCEEDS recommended limits: Men: > 14 drinks per week **OR** > 4 drinks on any occasion Women: > 7 drinks per week **OR** > 3 drinks on any occasion	conduct BRIEF counseling* AND consider referral for further evaluation	

* **BRIEF** counseling: **B**ring attention to elevated level of drinking; **R**ecommend limiting use or abstaining; **I**nform about the effects of alcohol on health; **E**xplore and help/support in choosing a drinking goal; **F**ollow-up referral for specialty treatment, if indicated.

b. Referral indicated for evaluation: ☐ Yes (Complete blocks 9 and 10) ☐ No (*Provide education/awareness as needed*)

State reason if AUDIT-C Score was 8+:

☐ Already under care
☐ Already has referral
☐ No significant impairment
☐ Other reason (*explain*): _____

4. PTSD screening as reported in Service member question (*MHA6*).

a. Did Service member mark yes on three or more of questions (*MHA6.a. through MHA6.e.*)?

☐ Yes ☐ No (*go to block 5*) ☐ Not answered by Service member

b. If yes, Service members responses to questions (*MHA6.f. through MHA6.v.*) resulted in a PCL-C score of (*X*), and the Service member's response to level of impairment with life events (*MHA6.w.*) is indicated in the table below.

Enter PCL-C Score: _____ ☐ (*MHA6.f.*) through (*MHA6.w.*) were not answered or are incomplete

Based on the PCL-C score, the Service member's level of functioning, and your exploration of responses, follow the guidance below.

Post-Traumatic Stress Disorder Intervention Matrix

Self-Reported Level of Functioning	PCL-C Score < 30 (*Sub-Threshold or no Symptoms*)	PCL-C Score 30 – 39 (*Mild Symptoms*)	PCL-C Score 40 – 49 (*Moderate Symptoms*)	PCL-C Score > 50 (*Severe Symptoms*)
☐ Not Difficult at All or Somewhat Difficult	No Intervention	Provide PTSD Education		Consider referral for further evaluation AND provide PTSD education*
☐ Very Difficult to Extremely Difficult	Assess need for further evaluation AND provide PTSD education*	Consider referral for further evaluation AND provide PTSD education*		Refer for further evaluation AND provide PTSD education*

* PTSD Education = Reassurance/supportive counseling, providing literature on PTSD, encourage self-management activities, and counsel Service member to seek help for worsening symptoms.

c. Referral indicated? ☐ Yes (*complete blocks 9 and 10*) ☐ No:

☐ Already under care
☐ Already has referral
☐ No significant impairment
☐ Other reason (*explain*): _____

5. Depression screening as reported in Service member question (*MHA7*).

a. Did Service member mark "More than half the days," or "Nearly every day" on question (*MHA7.a. or MHA7.b.*)?

☐ Yes ☐ No (*go to block 6*) ☐ Not answered by Service member

b. If yes, Service member's responses to questions (*MHA7.a. – MHA7.h.*) resulted in a PHQ-8 score of (*X*), and the Service member's response level of impairment with life events (*MHA7.i.*) is indicated in the table below.

Enter PHQ-8 Score: _____ ☐ (*MHA7.c.*) through (*MHA7.i.*) were not answered or incomplete

Based on the PHQ-8 score, Service member's level of functioning, and exploration of responses, follow the guidance below.

Depression Intervention Matrix

Self-Reported Level of Functioning	PHQ-8 Score 1-4 (*No Symptoms*)	PHQ-8 Score 5 – 9 (*Sub-Threshold Symptoms*)	PHQ-8 Score 10 – 14 (*Mild Symptoms*)	PHQ-8 Score 15 - 18 (*Moderate Symptoms*)	PHQ-8 Score 19 – 24 (*Severe Symptoms*)
☐ Not Difficult at All or Somewhat Difficult	No Intervention	Depression Education*		Consider referral for further evaluation AND provide depression education*	Consider referral for further evaluation AND provide depression education*
☐ Very Difficult to Extremely Difficult	Assess need for further evaluation AND provide depression education*		Consider referral for further evaluation AND provide depression education*	Consider referral for further evaluation AND provide depression education*	Refer for further evaluation AND provide depression education*

*Depression Education = Reassurance/supportive counseling, provide literature on depression, encourage self-management activities, and counsel Service member to seek help for worsening symptoms.

c. Referral indicated? ☐ Yes (*complete blocks 9 and 10*) ☐ No:

- ☐ Already under care
- ☐ Already has referral
- ☐ No significant impairment
- ☐ Other reason (*explain*): _____

6. Suicide risk evaluation.

a. **Ask** "Over the **PAST MONTH**, have you wished you were dead or wished you could go to sleep and not wake up?"

☐ Yes ☐ No

b. **Ask** "Have you actually had any thoughts of killing yourself?"

☐ Yes ☐ No (*go to question 6.f.1*)

c. **Ask** "Over the **PAST MONTH**, have you been thinking about how you might do this?"

☐ Yes ☐ No

d. **Ask** "Over the **PAST MONTH**, have you had these thoughts and had some intention of acting on them?"

☐ Yes ☐ No

e.1. **Ask** "Over the **PAST MONTH**, have you started to work out or worked out the details of how to kill yourself?"

☐ Yes ☐ No (*skip to 6.f.1.*)

e.2. **Ask** "At any time in the **PAST MONTH**, did you intend to carry out this plan?"

☐ Yes ☐ No

f.1. **Ask** "In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life?"

☐ Yes ☐ No (*skip to 6.g.*)

f.2. **Ask** "Was this within the past three months?"

☐ Yes ☐ No

g. **Conduct further risk assessment** (*e.g., interpersonal conflicts, social isolation, alcohol/substance abuse, hopelessness, severe agitation/anxiety, diagnosis of depression or other psychiatric disorder, recent loss, financial stress, legal disciplinary problems, or serious physical illness*).

Comments:

h. Does Service member pose a current risk of harm to self?

☐ Yes ☐ No

7. Violence/harm risk evaluation.

a. **Ask** "Over the past month have you had thoughts or concerns that you might hurt or lose control with someone?"

☐ Yes ☐ No (*go to block 8*)

If yes, ask additional questions to determine extent of problem (target, plan, intent, past history).
Comments:

b. Does the member pose a current risk to others?

☐ Yes (*complete blocks 9 and 10*) ☐ No

If no, briefly state reason:

8. Service member issues with this assessment (*mark as appropriate*):

☐ Service member declined to complete this form ☐ Service member declined to complete interview/assessment

Assessment and Referral: After review of the Service member's response and interview with the Service member, the assessment and need for further evaluation is indicated in blocks 9 through 12.

9. Summary of Provider's identified concerns needing referral(s) *(Mark all that apply)*:

	YES	NO		YES	No
a. None Identified ☐			g. Depression Symptoms	☐	☐
b. Physical Health	☐	☐	h. Environmental/Work Exposure	☐	☐
c. Dental Health	☐	☐	i. Risk of Self-Harm	☐	☐
d. Mental Health Symptoms	☐	☐	j. Risk of Violence	☐	☐
e. Alcohol Use	☐	☐	k. Other (*List*):	☐	☐
f. PTSD Symptoms	☐	☐			

10. Recommended referral(s) *(Mark all that apply even if the Service member does not desire)*:

	WITHIN 24 HOURS	WITHIN 7 DAYS	WITHIN 30 DAYS		WITHIN 24 HOURS	WITHIN 7 DAYS	WITHIN 30 DAYS
a. Primary Care, Family Practice, Internal Medicine	☐	☐	☐	f. Case Manager/Care Manager	☐	☐	☐
b. Behavioral Health in Primary Care	☐	☐	☐	g. Substance Abuse Program	☐	☐	☐
c. Mental Health Specialty Care	☐	☐	☐	h. Other (*List*):	☐	☐	☐
d. Dental	☐	☐	☐				
e. Other Specialty Care:							
Audiology	☐	☐	☐				
Dermatology	☐	☐	☐				
OB/GYN	☐	☐	☐				
Physical Therapy	☐	☐	☐				
TBI/Rehab Med	☐	☐	☐				
Podiatry	☐	☐	☐				
Other (*List*):	☐	☐	☐				

11. Comments:

12. Address requests as reported on Service member questions 7 through 10 (*in Service Member Section VI. Behavioral Health*)

Service Member Question	**Not Answered**	**Yes Response**	**Comments *(If Indicated)***
Request medical appointment	☐	☐	
Request Information on stress/emotional/alcohol	☐	☐	
Family/Relationship concern assistance	☐	☐	
Chaplain/mental health care provider/counselor visit request	☐	☐	

13. Supplemental services recommended/information provided.

☐ No Supplemental Services Required

☐ Other (*List*):

☐ Appointment Assistance:

☐ Contract Support:

☐ Community Service:

☐ Chaplain

☐ Health Education and Information

☐ Health Care Benefits and Resources Information

☐ Family Support

☐ Military One Source

☐ TRICARE Provider

☐ VA Medical Center or Community Clinic

☐ Veteran's Center

☐ In Transition

☐ I hereby certify that the Mental Health Assessment process has been completed.

Mental Health Assessment (*MHA*) Provider Digital Signature (*Sign if completing ONLY PART C, Section II, Mental Health Assessment portion of the PHA*):	Date Completed (*dd/mmm/yyyy*):

STOP HERE IF YOU ARE A MENTAL HEALTH ASSESSMENT PROVIDER COMPLETING ONLY THE MHA SECTION OF THE PHA.

This form must be completed electronically. Handwritten forms will not be accepted.

III. PERIODIC HEALTH ASSESSMENT (*PHA*) PROVIDER INFORMATION

1. Last Name:	2. First Name:	3. Middle Name:

4. Service Branch:

- ☐ Air Force
- ☐ Army
- ☐ Navy
- ☐ Marine Corps
- ☐ Coast Guard
- ☐ U.S Public Health Service
- ☐ Other *(e.g., RHRP contractor)*

5. Status:

- ☐ Active Duty
- ☐ Traditional Guardsman
- ☐ Reservist
- ☐ Active Guard Reserve or Full-time Support
- ☐ Civilian Government Employee
- ☐ Civilian Contractor
- ☐ Other *(List)*: _____

6. Select the appropriate title.

- ☐ Physician (*MD, DO*)
- ☐ Nurse Practitioner (*NP*)
- ☐ Physician Assistant (*PA*)
- ☐ Advance Practice Nurse (*Clinical Nurse Specialist*)
- ☐ Independent Duty Corpsman
- ☐ Independent Duty Health Services Technician
- ☐ Independent Duty Medical Technician
- ☐ Special Forces Medical Sergeant

7. Email:	8. Facility:	9. Unit:

10. Address:	11. State:	12. ZIP Code:	14. Date HCP Review Initiated *(dd/mmm/yyyy)*:
	13. Phone *(Commercial)*:		

IV. PERIODIC HEALTH ASSESSMENT PROVIDER RECOMMENDATIONS & REFERRALS

1. Provider concerns with this assessment (*mark as appropriate*):

- ☐ No issues or concerns identified. (*Skip to Section V. Summary & Comments*)
- ☐ Issue or concerns identified after review of Service member responses, medical documentation, and Mental Health Assessment. (*Continue*)
- ☐ Issue or concerns identified after review of Service member responses, medical documentation, Mental Health Assessment, and person-to-person (*or face-to-face*) Service member interview. (*Continue*)
- ☐ Service member would like to schedule an appointment with a health care provider to discuss their health concerns. (*Continue*)

Assessment and Referral: Provider concerns and recommended referrals are indicated in blocks 2 through 4.

2. Summary of Provider's identified concerns *(Mark all that apply)*:

None Identified ☐

	YES	NO
a. Physical Health	☐	☐
b. Dental Health	☐	☐
c. Environmental/Work Exposure	☐	☐
d. Alcohol Use	☐	☐
e. PTSD Symptoms	☐	☐
f. Depression Symptoms	☐	☐
g. Mental Health Symptoms	☐	☐
h. Risk of Self-Harm	☐	☐
i. Risk of Violence	☐	☐
j. Other (*List*):	☐	☐

3. Recommended referral(s) *(Mark all that apply even if the Service member does not desire)*:

	WITHIN 24 HOURS	WITHIN 7 DAYS	WITHIN 30 DAYS
a. Primary Care, Family Practice, Internal Medicine	☐	☐	☐
b. Behavioral Health in Primary Care	☐	☐	☐
c. Mental Health Specialty Care	☐	☐	☐
d. Dental	☐	☐	☐
e. Other Specialty Care:			
Audiology	☐	☐	☐
Optometry	☐	☐	☐
Dermatology	☐	☐	☐
OB/GYN	☐	☐	☐
Physical Therapy	☐	☐	☐
TBI/Rehab Med	☐	☐	☐
Podiatry	☐	☐	☐
Other (*List*):	☐	☐	☐
f. Case Manager/Care Manager	☐	☐	☐
g. Substance Abuse Program	☐	☐	☐
h. Orthopedics	☐	☐	☐
i. Environmental/Occupational Health	☐	☐	☐
j. Family Advocacy Services	☐	☐	☐
k. Other (*List*):	☐	☐	☐

This form must be completed electronically. Handwritten forms will not be accepted.

V. SUMMARY AND COMMENTS

1. Additional information summarizing findings (*if any*) during the Service member assessment.

PHA CATEGORIES	PROVIDER SUMMARY & COMMENTS (Optional)
☐ I. Service Member Information and Demographics	
☐ II. Deployment Information	
☐ III. Occupational Information	
☐ IV. Medical Conditions	
☐ V. Individual Medical Readiness	
☐ VI. Behavioral Health	
☐ VII. Family History and Lifestyle	
☐ VIII. Women's Health	
☐ IX. Reserve Component	
☐ X. Other Medical	
☐ XI. Separation and Retirement	

2. Provider Comments:

VI. INDIVIDUAL MEDICAL READINESS DISPOSITION DETERMINATION

IMR STATUS	R	NR	Based on your review of all responses and documentation, what is the IMR disposition of the Service member?
DLMC	☐	☐	☐ **FULLY MEDICALLY READY.** (*Service members who are current in DoD PHA* (*completed*), *dental readiness assessment classified as DRC 1 or 2, immunization status, medical readiness and laboratory studies, individual medical equipment; and without any deployment-limiting medical conditions.*)
DEN	☐	☐	☐ **PARTIALLY MEDICALLY READY.** (*Service members who are lacking one or more of the following required immunizations, medical readiness laboratory studies, individual medical equipment, overdue DoD PHA, and/or DRC4. This category is the main focus of a commanders required actions and contains IMR deficits that are Service member actionable and must be corrected immediately upon identification to ensure these Service members remain and/or become fully medically ready to deploy.*)
IMM	☐	☐	
LAB	☐	☐	☐ **NOT MEDICALLY READY.** (*Service members with a chronic or prolonged deployment-limiting medical or mental condition as described in DoDI 6490.07. These conditions may also include hospitalization, recovery, or rehabilitation time from serious illness or injury, and/or individuals in DRC 3. Commanders should ensure those with a DRC 3 are addressed immediately upon identification to ensure these Service members become fully medically ready to deploy.*)
ME	☐	☐	
			☐ Service member has separated or retired; medical readiness determination NOT required.

KEY: DLMC – Duty Limiting Medical Condition, DEN – Dental, IMM – Immunizations, LAB – Laboratory, ME – Medical Equipment
R – READY (*Individual Medical Readiness element IS complete.*)
NR – NOT READY (*Individual Medical Readiness element is NOT complete. Item(s) missing, due or overdue.*)
Reference: DoDI 6025.19, Individual Medical Readiness (*IMR*), June 9, 2014

VII. SERVICE MEDICAL DEPLOYABILITY EVALUATION INDICATED

Based on your review of all documentation, is the Service member medically deployable without limitations? Reference DoDI 6490.07

☐ Yes (*Service member DOES NOT currently have a medical condition that limits deployability*)

☐ No (*Service member currently has a concern/medical condition that DOES NOT require duty limitation(s), but COULD limit deployability*)

☐ No (*Service member currently has a medical condition that DOES require duty limitation(s) AND limits deployability*)

VIII. CERTIFICATION AND CODING

☐ I hereby certify that the Periodic Health Assessment has been completed.	☐ This visit is ICD-10 coded by DOD_0225

IX. PERIODIC HEALTH ASSESSMENT (*PHA*) PROVIDER DIGITAL SIGNATURE AND COMPLETION DATE

Periodic Health Assessment (*PHA*) Provider Digital Signature:	Date Completed (*dd/mmm/yyyy*):