

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	<input type="checkbox"/> YES / <input type="checkbox"/> NO	
b. HEENT	<input type="checkbox"/> YES / <input type="checkbox"/> NO	
c. Lymph Glands	<input type="checkbox"/> YES / <input type="checkbox"/> NO	
d. Cardiovascular (Auscultation)	<input type="checkbox"/> YES / <input type="checkbox"/> NO	
If Murmur present	Standing makes it:	<input type="checkbox"/> Louder <input type="checkbox"/> Softer <input type="checkbox"/> No Change
	Squatting makes it:	<input type="checkbox"/> Louder <input type="checkbox"/> Softer <input type="checkbox"/> No Change
	Valsalva makes it:	<input type="checkbox"/> Louder <input type="checkbox"/> Softer <input type="checkbox"/> No Change
e. Vascular		
Carotid Pulses	<input type="checkbox"/> YES / <input type="checkbox"/> NO	
Femoral Pulses	<input type="checkbox"/> YES / <input type="checkbox"/> NO	
Pedal Pulses	<input type="checkbox"/> YES / <input type="checkbox"/> NO	
f. Lungs: Auscultation/Percussion	<input type="checkbox"/> YES / <input type="checkbox"/> NO	
g. Chest Contour	<input type="checkbox"/> YES / <input type="checkbox"/> NO	
h. Skin	<input type="checkbox"/> YES / <input type="checkbox"/> NO	
i. Abdomen and Viscera	<input type="checkbox"/> YES / <input type="checkbox"/> NO	
j. Genito-urinary	<input type="checkbox"/> YES / <input type="checkbox"/> NO	
k. Extremities	<input type="checkbox"/> YES / <input type="checkbox"/> NO	
l. Spine, other musculoskeletal	<input type="checkbox"/> YES / <input type="checkbox"/> NO	
m. Gross neurological (reflexes)	<input type="checkbox"/> YES / <input type="checkbox"/> NO	

8. ASSESSMENTGENERAL HEALTH Excellent Good Fair PoorExaminer'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 / NAe. Corrective lenses prescription reviewed: YES / NO / NAf. Date dental exam completed (DD/MM/YYYY): _____ Dental Class I II III IVg. 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 NoPost-Deployment Health Assessment (DD2796) in record? Yes NoPost-Deployment Health Re-Assessment (DD2900) in record? Yes NoAny 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 _____