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

ANNUAL PERIODIC HEALTH ASSESSMENT

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personally identifiable information through the DD Form 3024, Periodic Health Assessment (PHA) and how it may be used.

AUTHORITY: 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. 1074f, Medical Tracking System for Members Deployed Overseas; 10 U.S.C. 1074m, Mental Health Assessments for the Members of the Armed Forces Deployed in Support of a Contingency Operation; DoDD 6490.02E, Comprehensive Health Surveillance; DoDI 6025.19, Individual Medical Readiness (IMR); DoDI 6490.03, Deployment Health; DoDI 6490.07, Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees; DoDI 6490.12, Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation; and E.O. 9397 (SSN), as amended.

PRINCIPAL PURPOSE(S): To obtain your information in order to assess the state of your health and to assist health care providers in making readiness determinations and recommending present or future care. The information provided may result in a referral for additional health care that may include dental or behavioral health care.

ROUTINE USES: Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx, and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Mandatory. If you choose not to provide complete information, comprehensive health care services may not be possible or administrative delays may occur. Failure to supply information may prevent medical authorities from appropriately applying medical standards to include, but not limited to, duty restrictions, mobility restrictions, etc., to prevent harm to the Service member, or fellow Service members and the mission of the Armed Forces. However, care will not be denied.

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 PAST 12 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 Name:**	
4. Today's Date (*dd/mmm/yyyy*):		**5. Date of Birth (*dd/mmm/yyyy*):**	**6. Age:**
7. Social Security Number:		**8. Gender:** ◯ Male	◯ Female

9. Provide your 10-digit DoD ID number located on the back of your CAC:

10. Service Branch:	**11. Status:**	**12. Pay Grade:**		
◯ Air Force	◯ Traditional Guardsman	◯ E1	◯ O1	◯ W1
◯ Army	◯ Reservist	◯ E2	◯ O2	◯ W2
◯ Navy	◯ Active Guard Reserve or Full-Time Support	◯ E3	◯ O3	◯ W3
◯ Marine Corps	◯ Active Duty	◯ E4	◯ O4	◯ W4
◯ Coast Guard		◯ E5	◯ O5	◯ W5
◯ U.S. Public Health Service		◯ E6	◯ O6	
◯ Other (List): _____ (*Skip to 16*)		◯ E7	◯ O7	
		◯ E8	◯ O8	
		◯ E9	◯ O9	
			◯ O10	

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

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

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*)? *(NA for Traditional Guardsman/Reservist*)

◯ Yes

◯ No

◯ Don't Know

18. Current contact information (*Select preferred method*):		**19. Point of contact who can reach you (*No health or medical information will be shared with your point of contact*):**	
◯ DSN Phone:		Name:	
◯ Other Phone(s):		Phone 1:	
◯ Email(s):		Phone 2:	
◯ RelayHealth, MiCare, Patient Portal: (*If applicable*)		Email:	
◯ 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.a. What is your military occupational code (*for example: MOS, AOC, AFSC, NEC, or Designator Code*)?

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

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

◯ Yes

◯ No

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

◯ Yes

◯ No

◯ Don't Know

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

IV. MEDICAL CONDITIONS (DLC)

1. Since your last PHA, 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 that impacts your duty performance	○	○	○	○
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	○	○	○	○

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

3. For any condition marked YES in question 1 and/or 2, 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 that impacts your duty performance	◯	◯
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 had any surgery since your last PHA?

◯ Yes (*Continue*)

◯ No (*Skip to 6.a.*)

5. What was the condition(s) for which you had surgery and the type of surgery?

5.a. Condition:	5.a.1. Type of Surgery:
5.b. Condition:	5.b.1. Type of Surgery:
5.c. Condition:	5.c.1. Type of Surgery:

6.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 7.a.*)

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

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

7.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 8.a.*)

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

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

◯ Yes (*Continue*)

◯ No (*Skip to 9.a.*)

8.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:

9.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 10.a.*)

◯ Never had to wear these items (*Skip to 10.a.*)

9.b. Please comment on these problems:

10.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 11.a. (Army and Air Force), or 12.a. (All Others)*)

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

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

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

11.a. Do you have a permanent profile (*Army*) or an Assignment Limitation Code C (*Air Force*)?

◯ Yes (*Continue*)

◯ No (*Skip to 12.a.*)

◯ Don't Know (*Skip to 12.a.*)

11.b. Why are you on a permanent profile (*Army*) or an Assignment Limitation Code C (*Air Force*)? (*Comments*):

12.a. Are you on a temporary profile or limited duty (*LIMDU/Light Limited Duty (LLD)*)?

◯ Yes (*Continue*)

◯ Yes, but I feel ready to be evaluated for return to full duty (*Continue*)

◯ No (*Skip to 13*)

12.b. Why are you on a temporary profile or limited duty? (*Comments*):

13. During the PAST 2 YEARS, how many times have you been placed on a temporary profile or on limited duty?

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

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

3. Do you have red medical warning "dog tags," and are they current?

◯ 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 glasses do you have?

◯ 0

◯ 1

◯ 2 or more

6. Do you have gas mask inserts?

◯ Yes

◯ No

VI. BEHAVIORIAL HEALTH (MHA)

1.a. Over the PAST MONTH, what major life stressors 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 (*for example, serious conflicts with others, relationship problems, or a legal, disciplinary, or financial problem*)?	◯ None (*Skip to 2.a.*), or ◯ Please list and explain:	
1.b. Are you currently in treatment or getting professional help for this concern?	◯ 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 problem are you CURRENTLY taking?

◯ None ◯ Please list:

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

◯ Never (*Skip to 5*) ◯ Monthly or less ◯ 2 – 4 times a month ◯ 2 – 3 times per week ◯ 4 or more times a week

4.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

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

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

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

5.a. Have had nightmares about it or thought about it when you did not want to?	◯ Yes	◯ No
5.b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?	◯ Yes	◯ No
5.c. Were constantly on guard, watchful or easily startled?	◯ Yes	◯ No
5.d. Felt numb or detached from others, activities, or your surroundings?	◯ Yes	◯ No

(NOTE: If two or more items on 5.a. through 5.d. are marked YES, continue to answer items 5.e. through 5.v.)

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
5.e. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	◯	◯	◯	◯	◯
5.f. Repeated, disturbing dreams of a stressful experience from the past?	◯	◯	◯	◯	◯
5.g. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	◯	◯	◯	◯	◯
5.h. Feeling very upset when something reminded you of a stressful experience from the past?	◯	◯	◯	◯	◯
5.i. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	◯	◯	◯	◯	◯
5.j. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	◯	◯	◯	◯	◯
5.k. Avoid activities or situations because they remind you of a stressful experience from the past?	◯	◯	◯	◯	◯
5.l. Trouble remembering important parts of a stressful experience from the past?	◯	◯	◯	◯	◯
5.m. Loss of interest in things that you used to enjoy?	◯	◯	◯	◯	◯
5.n. Feeling distant or cut off from other people?	◯	◯	◯	◯	◯
5.o. Feeling emotionally numb or being unable to have loving feelings for those close to you?	◯	◯	◯	◯	◯
5.p. Feeling as if your future will somehow be cut short?	◯	◯	◯	◯	◯
5.q. Trouble falling or staying asleep?	◯	◯	◯	◯	◯
5.r. Feeling irritable or having angry outbursts?	◯	◯	◯	◯	◯
5.s. Having difficulty concentrating?	◯	◯	◯	◯	◯

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

	Not at All	A Little Bit	Moderately	Quite a Bit	Extremely
5.t. Being "super alert" or watchful, on guard?	◯	◯	◯	◯	◯
5.u. Feeling jumpy or easily startled?	◯	◯	◯	◯	◯

	Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
5.v. How difficult have these problems (*5.e. through 5.u.*) made it for you to do your work, take care of things at home, or get along with other people?	◯	◯	◯	◯

6. 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
6.a. Little interest or pleasure in doing things	◯	◯	◯	◯
6.b. Feeling down, depressed, or hopeless	◯	◯	◯	◯

(NOTE: If 6.a. or 6.b. are marked "More than half the days" or "Nearly every day," continue to answer items 6.c. through 6.i.)

	Not at All	Few or Several Days	More Than Half the Days	Nearly Every Day
6.c. Trouble falling/staying asleep, sleep too much.	◯	◯	◯	◯
6.d. Feeling tired or having little energy.	◯	◯	◯	◯
6.e. Poor appetite or overeating.	◯	◯	◯	◯
6.f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	◯	◯	◯	◯
6.g. Trouble concentrating on things, such as reading the newspaper or watching television.	◯	◯	◯	◯
6.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
6.i. How difficult have these problems (*6.a. through 6.h.*) made it for you to do your work, take care of things at home, or get along with other people?	◯	◯	◯	◯

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

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

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

10. Would you like to schedule a visit with a chaplain 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*)

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

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 ⊡rela tedonditions 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	◯	◯	◯	◯	◯	◯
Type II	◯	◯	◯	◯	◯	◯
Unknown	◯	◯	◯	◯	◯	◯

6. In a typical week, I do VIGOROUS physical activities: *(VIGOROUS activities cause HEAVY sweating or LARGE increases in breathing or heart rate*)

	Day(s) per week *(if 0, skip to question 7*)
	Minutes per day on the day(s) you work out

7. In a typical week, I do LIGHT OR MODERATE physical activities: *(LIGHT OR MODERATE activities cause ONLY LIGHT sweating or a SLIGHT to MODERATE increase in breathing or heart rate*)

	Day(s) per week *(if 0, skip to question 8*)
	Minutes per day on the day(s) you work out

8. 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

9. Which of the following products, or products marketed for the following purposes, have you taken, even once, since your last PHA? *Mark all that apply.*

◯ 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

9. Which of the following products, or products marketed for the following purposes, have you taken, even once, since your last PHA? *(Continued)*

◯ Multi-Vitamins

◯ Individual Vitamins or Minerals

◯ Omega-3 Supplements

◯ Joint Care Supplements

◯ None of the above (*Skip to 11*)

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	◯	◯	◯	◯	◯	◯
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 to 3 Servings per Day	4 or More Servings per Day
Fruits	◯	◯	◯	◯	◯	◯
Vegetables	◯	◯	◯	◯	◯	◯
Whole Grains	◯	◯	◯	◯	◯	◯
Dairy	◯	◯	◯	◯	◯	◯
Fish	◯	◯	◯	◯	◯	◯
Lean Protein	◯	◯	◯	◯	◯	◯
Sugar-Sweetened Beverages	◯	◯	◯	◯	◯	◯

12. (*If Traditional Guardsman or Reservist*) 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

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

◯ Cigarettes (*If marked, SM must complete 13.c.*)
◯ 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. (*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 ◯ 7 to 9 hours

◯ 5 to less than 7 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*):

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

◯ I am at risk

◯ I am not at risk

21. (*For males who identify "I am at risk" (Question LIF20)*) Have you had a syphilis, chlamydia, and gonorrhea test since your last PHA?

◯ Yes

◯ No

22. Since your last PHA, what, if anything, have you and your partner used to keep from getting pregnant? *Mark all that apply.*

◯ N/A: Was not sexually active with a member of the opposite sex or was not sexually active

◯ Trying to become pregnant so did not use anything

◯ Sterilization (*for example: vasectomy, tubal sterilization, trans-cervical sterilization, hysterectomy*)

◯ IUD (*including copper or progesterone*)

◯ Implant

◯ Birth control pills/contraceptive patch/vaginal ring/injectable

◯ Condoms

◯ Withdrawal or "pulling out"

◯ Rhythm by calendar/temperature/cervical mucus test

◯ Cervical cap/diaphragm

◯ Emergency contraception (*such as Plan B*)

◯ Not trying to become pregnant, but did not use anything

◯ Other (*explain*):

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

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

1. Which of the following best describes you?

◯ I am or may be pregnant (*Skip to 4*)

◯ 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*)

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

◯ Yes (*Skip to 6*)

◯ No (*Continue*)

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

◯ Yes (*Skip to 6*)

◯ No (*Continue*)

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

◯ Yes

◯ No

◯ Don't Know

5. 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

6. 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

7. (*If Question 2 is "No" or "Blank"*) Have you had a Pap test (*cervical cancer screening*) within the PAST 3 YEARS?

◯ Yes

◯ No

◯ Don't Know

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

◯ Yes

◯ No

9. (*If pregnant or may be pregnant (Question 1) and/or "At Risk" (Question LIF20)*) Have you had a syphilis, chlamydia and gonorrhea test since your last PHA?

◯ Yes

◯ No

10. Do you have a history of gestational diabetes?

◯ Yes

◯ No

IX. RESERVE COMPONENT (TRADITIONAL GUARDSMEN AND RESERVISTS ONLY, NOT AGR/FTS) (RES)

(Questions are for Traditional Guardsmen and Reservist). 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

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

3. What prescriptions or over-the-counter medications are you CURRENTLY taking, NOT INCLUDING vitamins, or nutritional supplements? Include ANY medications or over-the-counter products you are ROUTINELY taking such as Tylenol, Advil, Sudafed, and/or aspirin.

◯ None ◯ Medications	(*List Medications*):

4. 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 6*)

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

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

6. 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

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

◯ Yes (*Continue*)

◯ No (*Skip to SEPARATION AND RETIREMENT*)

8. Comment on these conditions and/or concerns. (*Comments*):

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 Speicalist)
- ◯ 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:	13. Phone (*Commercial*):

14. Date Record Review Initiated (*dd/mmm/yyyy*):

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

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

7. (*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

8. List of Service member's active medications listed in their permanent medical record: ◯ No Active Medications Documented

(*List*):

9. Is there a discrepancy between the active medication record review and the Service member's self-reported list of medications? (*Medications from OTH3 and MHA3*)

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

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

10. 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

11. Is there a discrepancy between the Service member's list of OUTSIDE care (*from OTH5*), and the OUTSIDE care found in the record (*see 10*)?

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

12. 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

13. (*If Service member reported having surgery since their last PHA in DLC4*) Is there documentation in the record for each surgery listed below?

CONDITION	TYPE OF SURGERY	YES	NO	Record Unavailable
(*List 1 from DLC5*):	(*List 1 from DLC5*):	◯	◯	◯
(*List 2 from DLC5*):	(*List 2 from DLC5*):	◯	◯	◯
(*List 3 from DLC5*):	(*List 3 from DLC5*):	◯	◯	◯

14. (*If Service member answered "Yes" in DLC10.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 DLC10.b.*).

◯ Confirmed All ◯ Not All Confirmed Comments:

15. (*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"*):

◯ No Discrepancies Noted

III. OCCUPATION-SPECIFIC EXAMINATIONS

1. (*If the Service member indicated they are required to have a special operational duty physical exam in OCC2*) When was the Service member's most recently documented special operational duty physical exam (*e.g., flight, jump, dive, missile, submarine, reliability program, or 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 OCC3*) 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 "I am at risk" in (LIF20)*) Is there a record of the Service member receiving a syphilis, chlamydia and gonorrhea test since their last PHA?

◯ Yes ◯ No

V. WOMEN'S HEALTH

1. (*If Service member reported she is or may be pregnant OR delivered in past 6 months in WOM1*) 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 WOM2*) 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 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

5. (*If Service member is or may be pregnant (WOM1), and/or is a female who identifies "At Risk" (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*) Service member indicated a return from deployment within the past 3 years. What is the status of each of the post-deployment health assessments?

ASSESSMENT TYPE	Completed	Missed Completion Window	Not Completed DUE	Not Completed NOT DUE Yet	Not Required for this Deployment
Post-Deployment Health Assessment (+/- 30 days of redeployment), DD Form 2796	◯	◯	◯	◯	◯
Post-Deployment Health Re-Assessment (90-180 days after return from deployment), DD Form 2900	◯	◯	◯	◯	◯
Mental Health Assessment (180 days to 18 months after return from deployment), DD Form 2978	◯	◯	◯	◯	◯
Mental Health Assessment (18 to 30 months after return from deployment), DD Form 2978	◯	◯	◯	◯	◯

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. (*For Army or Air Force Service Members only*) Does the Service member have a permanent profile (*if Army*), or an Assignment Limitation Code C (*if Air Force*)?

◯ Yes ◯ No

2. (*If answered "Yes" or "Yes, but" to DLC12.a.*) How many months in the past year has the Service member been in temporary duty / temporary profile / light duty / limited duty / LIMDU / 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 | ◯ 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:

S A M P L E

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

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
◯ Licensed Clinical Social Worker

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

10. Address:	**11. State:**	**12. ZIP Code:**	**13. Phone (*Commercial*):**

14. Date MHA Provider Review Initiated (*dd/mmm/yyyy*):

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

Service member reports most recent deployment was 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
◯ No significant impairment
◯ Already has referral
◯ Other reason *(explain)*: _____

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

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 (MHA4).

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; Follow-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 (*MHA5*).

a. Did Service member mark yes on two or more of questions (*MHA5.a. through MHA5.d*)?
◯ Yes ◯ No (*go to block 5*) ◯ Not answered by Service member

b. If yes, Service members responses to questions (*MHA5.e. through MHA5.u.*) resulted in a PCL-C score of (X), and the Service member's response to level of impairment with life events (*MHA5.v.*) is indicated in the table below.
Enter PCL-C Score: ◯ (*MHA5.e.*) through (*MHA5.v.*) 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 (*MHA6*).

a. Did Service member mark "More than half the days," or "Nearly every day" on question (*MHA6.a. or MHA6.b.*)?

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

b. If yes, Service member's responses to questions (*MHA6.a. – MHA6.h.*) resulted in a PHQ-8 score of (*X*), and the Service member's response level of impairment with life events (*MHA6.i.*) is indicated in the table below.

Enter PHQ-8 Score:_____ ◯ (*MHA6.c.*) through (*MHA6.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 been bothered by thoughts that you would be better off dead or of hurting yourself in some way?"

◯ Yes

◯ No (*go to block 7*)

b. If 6.a. was yes, **ask**: "How often have you been bothered by these thoughts?"

◯ Few or several days

◯ More than half of the time

◯ Nearly every day

c. If 6.a. was yes, **ask**: "Have you had thoughts of hurting yourself?"

◯ Yes (*If yes, ask questions 6.d. through 6.g.*)

◯ No (*If no thoughts of self-harm, go to block 7*)

d. **Ask** "Have you thought about how you might actually hurt yourself?"

◯ Yes ◯ No If Yes, how?

e. **Ask** "There is a big difference between having a thought and acting on a thought. How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life over the next month?"

◯ Not at all likely ◯ Somewhat likely ◯ Very likely

f. **Ask** "Is there anything that would prevent or keep you from harming yourself?"

◯ Yes ◯ No If Yes, what?

g. **Ask** "Have you ever attempted to harm yourself in the past?"

◯ Yes ◯ No If Yes, how?

h. **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:

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

◯ Yes (*complete blocks 9 and 10*) ◯ 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	◯	◯			

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

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**
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	◯	◯	◯
Dermatology	◯	◯	◯
OB/GYN	◯	◯	◯
Physical Therapy	◯	◯	◯
TBI/Rehab Med	◯	◯	◯
Podiatry	◯	◯	◯
Other	◯	◯	◯

	WITHIN 24 HOURS	**WITHIN 7 DAYS**	**WITHIN 30 DAYS**
f. Case Manager/Care Manager	◯	◯	◯
g. Substance Abuse Program	◯	◯	◯
h. Other (List):	◯	◯	◯

11. Comments:

S A M P L E

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/Counselor visit request	◯	◯	

13. Supplemental services recommended/information provided.

◯ Appointment Assistance:	◯ Family Support	◯ Other (*List*):
◯ Contract Support:	◯ Military One Source	
◯ Community Service:	◯ TRICARE Provider	
◯ Chaplain	◯ VA Medical Center or Community Clinic	
◯ Health Education and Information	◯ Veteran's Center	
◯ Health Care Benefits and Resources Information	◯ 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

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 / 13. Phone (*Commercial*):
14. Date HCP Review Initiated (*dd/mmm/yyyy*)		

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*)

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*):	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	◯	◯	◯
Dermatology	◯	◯	◯
OB/GYN	◯	◯	◯
Physical Therapy	◯	◯	◯
TBI/Rehab Med	◯	◯	◯
Podiatry	◯	◯	◯
Other	◯	◯	◯
f. Case Manager/Care Manager	◯	◯	◯
g. Substance Abuse Program	◯	◯	◯
h. 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:

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

VI. INDIVIDUAL MEDICAL READINESS DISPOSITION DETERMINATION

IMR STATUS	R	NR
DLC	☐	☐
DEN	☐	☐
IMM	☐	☐
LAB	☐	☐
ME	☐	☐

◯ **FULLY MEDICALLY READY.** (*Service member is current in 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.*)

◯ **PARTIALLY MEDICALLY READY.** (*Service member is lacking one or more immunizations, medical readiness laboratory studies, and/or individual medical equipment.*)

◯ **NOT MEDICALLY READY.** (*Service member has a chronic or prolonged deployment-limiting medical or mental condition. These conditions may also include hospitalization, recovery, or rehabilitation time from serious illness or injury, and/or individuals in DRC 3.*)

◯ **MEDICAL READINESS INDETERMINATE.** (*Inability to determine the Service member's current health status because of missing health information such as a lost medical record, an overdue PHA, and/or being in DRC 4.*)

◯ Service member has separated or retired; medical readiness determination NOT required.

KEY: DLC – Duty Limiting 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. CERTIFICATION AND CODING

◯ **I hereby certify that the Periodic Health Assessment has been completed.**

◯ **This visit is ICD-10 coded by DOD_0225**

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

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