

Periodic Health Assessment (PHA) Check-off Sheet (RC)

Name: _____

Date: _____

Unit: _____

SSN: _____

Staff initials:

PHA CLINIC:

- Height Weight BMI Blood Pressure Acuity Screening EKG
 Audiology Other: _____

LABORATORY:

- HIV DNA G6PD Blood Type
 Other: _____

IMMUNIZATIONS:

- PPD Influenza Tetanus-Diphtheria Hep A MMR Hep B
 DIPV Other: _____

DENTAL RECORD REVIEW/EXAM:

- Service Member(SM) with Dental Form (DD Form 2813) from Civilian Dentist.
 Type 2 Dental Exam Date _____ If no Type 2 Dental Exam within 13 months (Class 4),
 If Dental Class 3 or 4, Dental Treatment requirements given to SM (Date & Time): _____

MILITARY PROVIDER APPOINTMENT: Date: _____

- Medical Warning Tags PFA Clearance Deployment-Related Conditions
 Current Illness/Injury Current Medications/Supplements Chronic Medical Conditions

WOMEN'S HEALTH RECOMMENDATIONS:

- Service Member with copies of test results from civilian provider.
 Pap Chlamydia Screen Clinical Breast Exam Mammography

OPTOMETRY

- Service Member with copy of Glasses Rx from civilian Provider.
 Inserts Needed Glasses needed

HEALTH PROMOTION PREVENTION COUNSELING:

- Tobacco Use Nutrition Physical Activity Safety Alcohol Use Dental Care
 Sleep Mental Health Sexuality Other: _____

REFERRALS: (Service Member must provide proof of referral follow-up)

- Civilian Healthcare Provider OB/GYN Civilian Eye Care Dental Care
 Other: _____

QUESTIONNAIRES

- HART- R or Fleet Health Risk Appraisal (HRA)
 Physical Activity Risk Factor Questionnaire (*Results reviewed with PHA staff*)
 Other _____

Please have each department initial upon completion.

ONCE YOU ARE DONE, REPORT BACK TO THE "PHA" OFFICE WITH YOUR MEDICAL RECORD

PHA Department Staff Use Only

MRRS Update 2766 Update SM needs to provide civil treatment record