DEPARTMENT OF HOMELAND SECURITY
U.S. COAST GUARD

# PERIODIC HEALTH ASSESSMENT

**PRIVACY ACT STATEMENT**

**Authority:** The authority for collection of information including social security number (SSN) is found in the Privacy Act of 1974, 5 U.S.C. § 552a.
**Purpose:** The purpose of this form is to report on the annual Periodic Health Assessment (PHA) which includes record review/verification, assessment and counseling of avoidable health risk factors, clinical preventative services (CPS) recommendations, deployment/operational health history, and individual medical readiness (IMR) assessment.
**Routine Uses:** Information will be used by personnel within the Coast Guard to determine a member's health and well-being and suitability for performance of the duties of their office, grade, rank or rating.
**Disclosure:** In the case of military personnel, the requested information is mandatory. Failure to respond may lead to administrative or disciplinary action against the member.

| Patient Name *(Last, First, MI)* | DoD ID Number | DOB | Age | Birth Sex ☐ male ☐ female | Date |
|---|---|---|---|---|---|
| | | | | | |

## SECTION 1: VITALS

☐ **Face-to-Face Interview**
☐ **Tele/Video Interview**

**Height** *(inches)*

**Weight** *(pounds)*

**BMI**

Reviewed records for recent vitals and trends

☐ Vitals Normal
☐ Refer to Medical Officer

## SECTION 2: DENTAL

CLASS: ☐ 1 ☐ 2 ☐ 3 ☐ 4

## SECTION 3: IME VERIFICATION

**Prescription Lenses** *(two pair)*
☐ Yes ☐ No ☐ N/A

**Ballistic Eyewear**
☐ Yes ☐ No ☐ N/A

**Gas Mask Inserts**
☐ Yes ☐ No ☐ N/A

**Medical Alert Tags**
☐ Yes ☐ No ☐ N/A

The Periodic Health Assessment (PHA) is a screening tool used by the Coast Guard to evaluate an individual's medical readiness. The assessment includes a record review/verification (when available), assessment and counseling of avoidable health risk factors, clinical preventive services (CPS) recommendations, deployment/operational health history, and individual medical readiness (IMR) assessment.

## SECTION 4: HEALTHCARE PROVIDER ASSESSMENT

1. Updated DD 2766 Sections *(check):* ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7
2. Does Member use Tobacco products? ☐ Yes ☐ No ☐ Smoke ☐ Smokeless ☐ Vape
3. Referred to PCM based on USPSTF recommendations? ☐ Yes ☐ No
4. If yes, specify:
5. Pain Level *(N/A to severe):* ☐ N/A ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
   Location(s):
6. Discussed Healthy Life Style? ☐ Yes ☐ No
7. Other health concerns?
   ☐ No health issues identified requiring a focused exam ☐ Focused exam required *(document on separate SF-600 i.e.* pregnancy, Duty Limited Medical Condition, shave chit, etc.)
8. Is the member currently enrolled in a medical surveillance/occupational health program?
   ☐ Yes ☐ No ☐ Don't Know If Yes, is physical current? ☐ Yes ☐ No ☐ Scheduled
9. Any unresolved operational or deployment health issues? ☐ Yes ☐ No
   If Yes, explain:
10. IMR Discrepancies? ☐ None ☐ HIV ☐ Audiogram ☐ Hep A ☐ Hep B ☐ TwinRix ☐ Influenza
    ☐ MMR ☐ Polio ☐ Smallpox ☐ Tet/Dip ☐ Yellow Fever ☐ Anthrax ☐ Typhoid ☐ Dental

## SECTION 5: DUTY STATUS ASSESSMENT

☐ **FULLY MEDICALLY READY.** (*Service member is current in PHA (completed), Dental Readiness Assessment classified as 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.*)

## SECTION 6: SERVICE MEMBER ACKNOWLEDGEMENT

Member informed and voiced understanding that completion of required/recommended test/immunizations/screening(s) shall be performed within the next 30 days and he/she is personally responsible for achieving/maintaining individual readiness.

**X** _____ Authorized Provider Signature

**X** _____ Member's Signature

_____ Authorized Provider Name & Credentials *(print/stamp)*

_____ Date

_____ Member's Name *(print)*

_____ Date

## SECTION 7: DSMO / DMOA USE ONLY

Comments:

_____ DSMO / DMOA Name *(print)*

**X** _____ Signature

_____ Date