PHA Worksheet

Rank / Rate Last Name First Name: DOD ID:

Personal cellphone number and work number (\*Note which number YOU want a PHONE CALL FOR THE TIME OF YOUR APPOINTMENT::

Height: \_\_\_\_\_ft.\_\_\_\_\_\_in.

Weight (lbs.):\_\_\_\_\_

LIMDU Status? \_\_\_\_\_ Started: \_\_\_\_

* Are you currently taking any Rx (prescription meds) or OTC (over the counter meds)? Yes\_\_\_\_ If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No\_\_\_\_\_
* Do you have any allergies? Yes\_\_\_\_ No\_\_\_\_

If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you wear glasses or contacts? \_\_\_\_\_If yes, do you have 2 pairs? \_\_\_\_\_\_
* Are you due for any Special Physicals (Flight/5yr Nuke/Explosive)? Yes\_\_\_ No\_\_\_

If yes, please list\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Have you deployed in the last 2 years? Yes\_\_\_\_ No\_\_\_\_
* Have you been to an ER/urgent Care within the past year? If so, for what? And when?

List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Have you been seen at this MTF or any MTF within the past year for anything significant?

List\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Tobacco usage? Type and Amount. Ex:1 can of Dip x 1 week
* Alcohol usage? Type (beer, liquor, wine) and amount Ex: 4 beers x 1 day
* Do you have an addiction to gambling? Yes\_\_\_\_ No\_\_\_\_

\*21-29 y/o every 3 years\* \*30-65 y/o every 5 years\*

Females Only:

Date of last Pap smear:

Result (normal/abnormal)