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 outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at http://dpcid.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		5. Date of Birth	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:

- ◯ Air Force
- ◯ Army
- ◯ Navy
- ◯ Marine Corps
- ◯ Coast Guard
- ◯ U.S. Public Health Service
- ◯ Other *(List):* _____ *(Skip to 16)*

11. Status:

- ◯ Traditional Guardsman
- ◯ Reservist
- ◯ Active Guard Reserve or Full-Time Support
- ◯ Active Duty

12. Pay Grade:

◯ E1	◯ O1	◯ W1
◯ E2	◯ O2	◯ W2
◯ E3	◯ O3	◯ W3
◯ E4	◯ O4	◯ W4
◯ E5	◯ O5	◯ W5
◯ E6	◯ O6	
◯ 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)?*** SM1CFNKF

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):

○ DSN Phone:
○ Other Phone(s):
○ Email(s):
○ RelayHealth, MiCare, Patient Portal: *(if applicable)*
○ Address: State: Zip Code:

19. Point of contact who can reach you (No health or medical information will be shared with your point of contact):

Name:
Phone 1:
Phone 2:
Email:
Address: State: 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, personnel reliability program, or 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

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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	○	○	○	○

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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	○	○
Recuring headaches/migraines	○	○
Head injury/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):

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 you are 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?

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 your 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?	○	○	○	○	○

	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)

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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 related conditions 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)*

7	Day(s) per week *(if 0, skip to question 7)*
15	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)*

5	Day(s) per week *(if 0, skip to question 8)*
15	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:

2	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?

◯ < .5 pack/day ◯ .5 to 1 pack/day ◯ 1.5 to 2 packs/day ◯ 2.5 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):*

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 on going 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 on going 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 GUARDMEN AND RESERVIST ONLY, NOT AGR/FTS) (RES)

(Questions are for Traditional Guardsman 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
- ◯ 2 = Notice pain, does not interfere with activities
- ◯ 3 = Sometmes distracts me
- ◯ 4 = Distracts me, can do usual activites
- ◯ 5 = Interrupts some activities
- ◯ 6 = Hard to ignore, avoid usual activities
- ◯ 7 = Focus of attention, prevents doing daily activites
- ◯ 8 = Awful, hard to do anything
- ◯ 9 = Can't bear the pain, unable to do anything
- ◯ 10 = As bad as it coud be, nothing else matters

2. Are you receiving treatment for pain?

- ◯ Yes
- ◯ No

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):*
Back pain	Demoko Chiropractor in Goldsboro

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