

## Periodic Health Assessment (PHA)

Dunham US Army Health Clinic  
450 Gibner Road, Suite 1, Carlisle, PA 17013-5086

Please complete the following questionnaire and bring it to your PHA appointment.

Name	Date of Birth	Daytime Phone
1. Are you allergic to anything? <input type="checkbox"/> Medicine <input type="checkbox"/> Food <input type="checkbox"/> Other If so, what?		
2. Do you have any ongoing medical problems? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list.		
3. Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list.		
4. Any overnight hospital stays? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list. <i>(Do not include hospitalizations for routine childbirth unless complications occurred or you had a caesarean section.)</i>		
5. Have you ever had high blood pressure? <input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Have you ever had high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. Have you ever had heart disease or angina? <input type="checkbox"/> Yes <input type="checkbox"/> No		
8. Have you ever had asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No		
9. Have you ever been diagnosed with diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No		
10. Are you currently taking any medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list. <i>(Please include any prescription medicines, over the counter medicines, vitamins, herbal supplements, and birth control pills.)</i>		
11. Are you on a profile? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please BRING a copy to your PHA appointment.		
12. Are you limited or prevented in any way from doing things most people can do (for example, work, go to school, do housework, run, exercise, take a PT test)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
13. Have you ever deployed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when and where?		

14. If you deployed, have you completed the post-deployment DD Form 2796 and the 90-180 day health reassessment, DD Form 2900?  Yes  No

15. Do you use tobacco products? If so, please indicate

- Cigarettes  Cigars  Chewing Tobacco

16. Do (or did) any of your close relatives (grandparents, parents, brothers, sisters) have cancer?  Yes  No

If yes, please list.

17. Do (or did) any of our close relatives (grandparents, parents, brothers, sisters) have a heart attack before age 50?

- Yes  No

If yes, please list.

18. Do (or did) any of your close relatives (grandparents, parents, brothers, sisters) have diabetes?  Yes  No

If yes, please list.

19. On an average day, how many servings of fruit or vegetables do you eat?

- None  1 - 2 servings  3 - 4 servings  5 or more servings

20. Do you drink alcohol?  Yes  No

If yes, \_\_\_\_ drinks per:

- day  
 week  
 month

I have felt I should cut down on my drinking.

I have felt bad or guilty about drinking.

People have annoyed me by criticizing my drinking.

I have had a drink first thing in the morning to steady my nerves or get rid of a hangover (eye-opener).

21. How often do you use your seat belt?

- Always  Sometimes  Never

22. How often do you exercise?

- None  1 - 2 times per week  3 - 4 times per week  5 or more times per week

23. In the last 2 weeks, how often have you been bothered by any of the following problems?

- Little interest or pleasure in doing things?  Feeling down, depressed, or hopeless?

24. Do you have any mental health or emotional problems for which you receive treatment or counseling or would like treatment or counseling?  Yes  No

25. Is there any reason why you feel you may not be medically deployable?  Yes  No

If yes, due to: