GSU PREVENTIVE HEALTH ASSESSMENT

GENERAL USE	*This form is to be completed in conjunction with the Annual Physical Review. The form is distributed by the Unit Health Monitor (UHM) to Service Member (SM) and is to be completed with a Provider, then returned to the Base Operational Medicine Clinic (BOMC).*
FORMAT	*The form to be filled digitally if possible. Date Format-* ***DDMMMYY.*** *Phone Number Format-* ***(xxx) xxx-xxxx.*** *SM's demographics and date of form completion should be filled out on top of all applicable pages.*
QUESTIONS OR CONCERNS	*Base Operational Medicine Clinic - 88amds.sgpf.bomc@us.af.mil P: (937)255-2515 F: (937)656-4062*
Preface: INDIVIDUAL MEDICAL READINESS CHECKLIST	***The UHM is to complete the preface in its entirety.*** They are to identify all Individual Medical Requirements (IMR) for SM in accordance with ASIMS IMR Section. The UHM is to annotate all demographics for contact, verification, and coordination of care purposes.
Section 1A: DEMOGRAPHICS	***SM is to complete Section 1A in its entirety.***
Section 1B: ALLERGIES AND MEDICATIONS	***SM is to complete Section 1B as applicable.*** Medication Allergies & Other Allergies- SM is to annotate all allergies and adverse reactions. Active Medications- SM is to annotate all current active medications (OTC or prescription), dosage, frequency of use, and start date.
Section 1C: FAMILY HISTORY	***SM is to complete Section 1C as applicable.*** SM is to annotate all medical conditions applicable to family members and the age of that family member at onset of condition (if known.)
Section 1D: PATIENT MEDICAL HISTORY	***SM to complete Section 1D in its entirety.*** Questions 1-19 - SM to mark "Yes" or "No" to reflect all past and/or current occurrences. Question 20 - SM to explain any "Yes" indications and/or list other pertinent conditions.
Section 2A: ANNUAL SCREENING EXAMS	***Provider to complete Section 2A in its entirety.*** Screening Exams- The provider should address height, weight, body mass index (BMI), and blood pressure by assessing and recording values from face-to-face (F2F) visit, ASIMS, or AHLTA. Preventative Screening Exams- the provider should address lipid panel, other risk factors, cardiac risk score, and any other factors deemed necessary as applicable age, gender, or other indications.
Section 2B: CLINICAL EVALUATION	***Provider to complete Section 2B in its entirety.*** The provider does not need to accomplish a full hands-on physical; clinical judgment will suffice for disposition of each exam component.
Section 2C: ACTIVE CONDITIONS	***Provider to complete Section 2C as applicable.*** Provider to annotate all pertinent active conditions within annual physical review (Diagnosis, date, cause, treatment, duration, recovery, recurrence, complications, sequelae).
Section 2D: PERFORMED PROCEDURES/TESTS	***Provider to complete Section 2D as applicable.*** The provider should annotate all procedures, laboratory tests, radiology results, pathology results, and other testing performed within annual physical review. Annotate significant values, impressions, and other pertinent data.
Section 3A: FITNESS/DUTY LIMITATIONS	***Provider to complete Section 3A in its entirety.*** The provider to assess the SM's ability to perform the 1.5 Mi Run/2.0 KM Walk, Push-ups, Sit-Ups, and physical activities pertaining to each component. If SM is capable of all aspects of a fitness component mark the "CLEARED" box. If not, mark the "NOT CLEARED" box and annotate rationale. Duty Restrictions- Provider to confer with SM concerning duty description and active conditions to correlate and recommend possible duty restrictions. Comment- Provider to determine why SM is unable to complete a component. (i.e., unable to do push-ups, or lift >40 lbs. due to broken finger)
Section 3B: RECOMMENDED CLINICAL PREVENTIVE SERVICES	***Provider to complete Section 3B as applicable.*** The provider is to assess, recommend, and annotate Clinical Preventative Services (CPS) based upon age, gender, and other risk factors in accordance with The United States Preventive Services Task Force (USPSTF), the electronic Preventive Services Selector (ePSS), and clinical judgment.
Section 3C: COUNSELING	***Provider to complete Section 3C as applicable.*** The provider to offer prevention counseling on the highlighted subjects in Section 3C. The provider may counsel on all subjects or only those pertinent to SM's health.
Section 4: FURTHER EVALUATION	***Provider to complete Section 4 as applicable.*** The provider is to utilize section 4 as a means to further elaborate any subject of SM's health.
Section 5: PROVIDER DEMOGRAPHICS	***Provider to complete Section 5 in its entirety.*** The provider to annotate all demographics of Section 5 for contact information and coordination of care

GSU PREVENTIVE HEALTH ASSESSMENT

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, DoD Instruction 6130.03, and E.O. 9397, as amended (SSN).

PRINCIPAL PURPOSE(S): The primary collection of this information is to help determine individual's qualification for duty, for security clearances, and for assignments. The personal information will facilitate and document your health care. As a record of a members medical/dental health, diagnosis, and treatment and disposition. An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted. Completed forms are covered by recruiting, medical evaluation board, and official military personnel file SORNs maintained by each of the Services.

ROUTINE USE(S): The use of this information is to provide, plan and coordinate health care.

DISCLOSURE: Voluntary. This all-inclusive Privacy Act Statement will apply to all requests for personal information made by health care treatment personnel or for medical/dental treatment purposes and will become a permanent part of your health care record. The SSN of the member is to ensure the collected information is filed in the proper individual's record (paper or electronic).

PREFACE: UNIT HEALTH MONITOR (UHM)

PREFACE: INDIVIDUAL MEDICAL READINESS CHECKLIST					
LABS	**MED READY**	**NOT MED READY**	**IMMUNIZATIONS**	**MED READY**	**NOT MED READY**
BLOOD TYPE	◯	◯	**HEP A**	◯	◯
RH	◯	◯	**HEP B**	◯	◯
SICKLE CELL	◯	◯	**HPV**	◯	◯
G6PD	◯	◯	**INFLUENZA**	◯	◯
HIV	◯	◯	**MMR**	◯	◯
DNA	◯	◯	**POLIO**	◯	◯
Dental Class	◯ **1** ◯ **2** ◯ **3** ◯ **4**		**PPD**	◯	◯
Comments:			**TD**	◯	◯
			VARICELLA	◯	◯
			OTHER _____	◯	◯

PREFACE: UHM DEMOGRAPHICS			
EMAIL	**DSN**	**UNIT**	**DATE**
RANK, LAST NAME, FIRST NAME	**SIGNATURE**		

SECTION 1 – TO BE COMPLETED BY SERVICE MEMBER

SECTION 1A: DEMOGRAPHICS

LAST NAME, FIRST NAME, MIDDLE INITIAL	DoDID	SSN LAST 4	DATE OF BIRTH	AGE	GENDER
					◯ Male ◯ Female

SERVICE	COMPONENT	FLYER?	RANK/GRADE	PHONE NUMBER
◉ AIR FORCE	(SELECT ONE) ◯ ACTIVE DUTY ◯ GUARD ◯ RESERVES	◯ YES ◯ NO ◯ ACTIVE ◯ INACTIVE		
PRAP? ◯ YES ◯ NO			OCCUPATION/AFSC	EMAIL

SECTION 1B: ALLERGIES AND MEDICATIONS

Medication Allergies and Reactions	Other allergies (Food, insects, latex, etc.)

Active medications (to include OTC and supplements; include dose, frequency, and start date)

SECTION 1C: FAMILY HISTORY

List cancer, cardiovascular disease, diabetes, mental illness/chemical dependency, other)
M- Mother, F- Father, MGM- Maternal Grandmother, MGF-Maternal Grandfather, PGM- Paternal Grandmother, PGF-Paternal Grandfather, S-Sibling

SECTION 1D: PATIENT MEDICAL HISTORY

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO	HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
1. a. Tuberculosis	○	○	h. Frequent or painful urination	○	○
b. Lived with someone who had Tuberculosis	○	○	i. High or low blood sugar	○	○
c. Coughed up blood	○	○	j. Kidney stone or blood in urine	○	○
d. Asthma, or any breathing problems related to exercise, weather, pollens, etc.	○	○	k. Sugar or protein in urine	○	○
			l. Sexually transmitted disease (syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)	○	○
e. Shortness of breath	○	○			
f. Bronchitis	○	○	**5**. a. Adverse reaction to serum, food, insect stings or medicine	○	○
g. Wheezing or problems with wheezing	○	○			
h. Been prescribed or used an inhaler	○	○	b. Recent unexplained gain or loss of weight	○	○
i. A chronic cough or cough at night	○	○	c. Currently in good health (if no, explain)	○	○
j. Sinusitis	○	○	d. Tumor, growth, cyst, or cancer	○	○
k. Hay fever	○	○	**6.** a Dizziness or fainting spells	○	○
l. Chronic or frequent colds	○	○	b. Frequent or severe headache	○	○
2. a. Severe tooth or gum trouble	○	○	c. A head injury, memory loss or amnesia	○	○
b. Thyroid trouble or goiter	○	○	d. Paralysis	○	○
c. Eye disorder or trouble	○	○	e. Seizures, convulsions, epilepsy or fits	○	○
d. Ear, nose, or throat trouble	○	○	f. Car, train, sea, or air sickness	○	○
e. Loss of vision in either eye	○	○	g. A period of unconsciousness or concussion	○	○
f. Worn contact lenses or glasses	○	○	h. Meningitis, encephalitis, or other neurological problems	○	○
g. A hearing loss or wear a hearing aid	○	○			
h. Surgery to correct vision (*RK, PRK, LASIK, etc*.)	○	○	**7**. a. Rheumatic fever	○	○
3. a Painful shoulder, elbow, or wrist (*e.g. pain, dislocation, etc.)*	○	○	b. Prolonged bleeding (as after injury or tooth extraction, etc.)	○	○
b**.** Arthritis, rheumatism, or bursitis	○	○	c. Pain or pressure in the chest	○	○
c. Recurrent back pain or any back problem	○	○	d. Palpitation, pounding heart or abnormal heart beat	○	○
d. Numbness or tingling	○	○			
e. Loss or finger or toe	○	○	e. Heart trouble or murmur	○	○
f. Foot trouble (*e.g. pain, corns, bunions, etc.)*	○	○	f. High or low blood pressure	○	○
g. Impaired use of arms, legs, hands, or feet	○	○	**8**. a. Nervous trouble of any sort (anxiety or panic attacks)	○	○
h. Swollen or painful joint(s)	○	○			
i**.** Knee trouble (*e.g. locking, giving out, pain or ligament injury, etc.)*	○	○	b. Habitual stammering or stuttering	○	○
			c. Loss of memory or amnesia, or neurological symptoms	○	○
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○			
			d. Frequent trouble sleeping	○	○
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	○	e. Received counseling of any kind	○	○
			f. Depression or excessive worry	○	○
			g. Been evaluated or treated for a mental condition	○	○
l. Bone, joint, or other deformity	○	○			
m. Plate(s), screw(s), rod(s), or pin(s) in any bone	○	○	**9**. FEMALES ONLY		
n. Broken bone(s) (*cracked or fractured*)	○	○	a. Treatment for a gynecological (female) disorder	○	○
4. a. Frequent indigestion or heartburn	○	○			
b. Stomach, liver, intestinal trouble, or ulcer	○	○	b. A change in your menstrual pattern/cycle	○	○
c. Gallbladder trouble or gallstones	○	○	c. Any abnormal PAP smears	○	○
d. Jaundice or hepatitis (*liver disease*)	○	○	d. First day of last menstrual period	○	○
e. Rupture/hernia	○	○	e. Date of last PAP smear	○	○
f. Rectal disease, hemorrhoids or blood from the rectum	○	○	Comments:		
g. Skin diseases (e.g. acne, eczema, psoriasis, etc.)	○	○			

SECTION 1D: PATIENT MEDICAL HISTORY (CONT.)					
HAVE YOU EVER HAD OR DO YOU NOW HAVE:	**YES**	**NO**	**HAVE YOU EVER HAD OR DO YOU NOW HAVE:**	**YES**	**NO**
10.Have you been refused employment or been unable to hold a job or stay in school because of:			**15.** Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)	○	○
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○			
b. Inability to perform certain motions	○	○			
c. Inability to stand, sit, kneel, lie down, etc.	○	○	**16.** Have you ever been rejected for military service for any reason? (If yes, give date and reason for rejection.)	○	○
d. Other medical conditions (if yes, give reasons)	○	○			
11. Have you ever been treated in an Emergency Room? (If yes, for what?)	○	○	**17.** Have you ever been discharged from military service for any reason? (If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)	○	○
12. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	○	○			
13. Have you ever had, or have you been advised to have any operations or surgery? (If yes, describe and give age at which occurred.)	○	○	**18.** Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? (If yes, specify what kind, granted by whom, and what amount, when, why.)	○	○
14. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	○	○	**19.** Have you ever been denied life insurance?	○	○

20. EXPLANATION(S) OF "YES" ANSWERS **Describe condition, date happened, name of doctor and/or hospital, treatment given, and current medical status.**

SECTION 2 – TO BE COMPLETED BY PROVIDER TEAM

SECTION 2A. SCREENING EXAMS			
EXAMS	**DATE COMPLETED**	**VALUES**	**COMMENTS**
HEIGHT (ins.)			q YR for AGE ≥ 18 YRS
WEIGHT (lbs.)			q YR for AGE ≥ 18 YRS
BODY MASS INDEX			q YR for AGE ≥ 18 YRS; Evaluate if BMI is ≤ 18.5 or ≥30.0
BLOOD PRESSURE		/	q YR for AGE ≥ 18 YRS; WNL= ≤ 140/90
LIPID PANEL		HDL: LDL: Trig: Total Chol:	q 5 YRS MALES ≥35YRS; FEMALES ≥45YRS ***If at Increased Risk** q 5 YRS FEMALES AGE 20-44 ***If at Increased Risk** q 5 YRS MALES AGE 20-34 ***Provider will determine if SM is at increased risk**
OTHER RISK FACTORS		HTN Meds? Smoker? Diabetic?	Criteria for risk factors (only one factor needed): Diabetes, personal history of CHD, smoking, hypertension, obesity (BMI > 30), family history of CHD (i.e., male relative under age 55 or female relative under age 65 with CHD), physical inactivity.
CARDIAC RISK SCORE			***Provider to determine risk factors and calculate score**
PAP (Females)		◯ Normal ◯ Abnormal	q 3 YRS AGES 21-65 YRS: If no recent abnormal cytology/HPV; if recent abnormal/HPV follow-up schedule per plan q 5 YRS AGES 30-65 YRS: If Combination Of Cytology & HPV Testing

SECTION 2B. CLINICAL EVALUATION							
WNL-Within Normal Limits, ABN-Abnormal, NE-Not Evaluated. **Clinical judgment will suffice in-lieu of Clinical Evaluation (i.e. a service member absent of nose defects or injuries can be presumed "WNL")**							
WNL	**ABN**	**NE**	**EXAM ELEMENTS**	**WNL**	**ABN**	**NE**	**EXAM ELEMENTS**
◯	◯	◯	1. Head, face, neck, and scalp	◯	◯	◯	15. Abdomen and viscera (include hernia)
◯	◯	◯	2. Nose	◯	◯	◯	16. External genitalia (genitourinary)
◯	◯	◯	3. Sinuses	◯	◯	◯	17. Upper Extremities
◯	◯	◯	4. Mouth and throat	◯	◯	◯	18. Lower Extremities (except feet)
◯	◯	◯	5. Ears—General (external canals)	◯	◯	◯	19. Feet ◯ Normal Arch ◯ Mild ◯ Asymptomatic ◯ Pes Cavus ◯ Moderate ◯ Symptomatic ◯ Pes Planus ◯ Severe
◯	◯	◯	6. Drums (perforation)				
◯	◯	◯	8. Ophthalmoscopic				
◯	◯	◯	9. Pupils	◯	◯	◯	20. Spine, other musculoskeletal
◯	◯	◯	10. Ocular Motility (Associated parallel movements, nystagmus)	◯	◯	◯	21. Identifying body marks, scars, tattoos
				◯	◯	◯	22. Skin, lymphatics
◯	◯	◯	11. Heart (thrust, size, rhythm, sounds)	◯	◯	◯	23. Neurologic
◯	◯	◯	12. Lungs and chest (include breasts)	◯	◯	◯	24. Psychiatric (specify any personality deviation)
◯	◯	◯	13. Vascular system (Varicosities, etc.)	◯	◯	◯	25. Pelvic (Females only)
◯	◯	◯	14. Anus and rectum (hemorrhoids, fistulae, Prostate (if indicated)	◯	◯	◯	26. Endocrine

SECTION 2C: ACTIVE CONDITIONS
(ICD 10 Code, Diagnosis, date, cause, treatment, duration, recovery, recurrence, complications, sequelae)
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

SECTION 2D: PERFORMED PROCEDURES/TESTS		
PROCEDURE/TEST	DATE PERFORMED	RESULTS
1.		
2.		
3.		
4.		
5.		
6.		
7.		

SECTION 3 – TO BE COMPLETED BY PROVIDER TEAM

SECTION 3A: FITNESS/DUTY LIMITATIONS			
CLEARED	NOT CLEARED	FITNESS COMPONENT	COMMENTS
○	○	**1.5 MI RUN/2.0 KM WALK** No running: _____ Other:_____	
○	○	**PUSH-UPS** No lifting/pushing/pulling _____ Other:_____	
○	○	**SIT-UPS** No repetitive bending of the waist Other_____	
○	○	**OTHER LIMITATIONS**	

SECTION 3B: RECOMMENDED CLINICAL PREVENTATIVE SERVICES

CLINICAL PREVENTIVE SERVICES
http://www.uspreventiveservicestaskforce.org/BrowseRec/Index)
****refer to website for the most up-to-date recommendations as they are updated regularly****

INDICATED	DATE COMPLETED	RESULTS			TEST	RECOMMENDATIONS
		WNL	ABN	NE		
☐		○	○	○	MAMMOGRAPHY (*Females*) Date of Last:_____	AGES 40-49 YRS: Shared decision between patient and provider; q 2 YRS AGE ≥ 50 YRS
☐		○	○	○	COLON CANCER Date of Last:_____	FECAL OCCULT BLOOD: q YRS AGE ≥ 50 YRS
☐		○	○	○		SIGMOIDOSCOPY: q 3-5 YRS AGE ≥ 50 YRS
☐		○	○	○		COLONOSCOPY: q 10 YRS AGE ≥ 50 YRS
☐		○	○	○	Hgb-A1C Date of Last:_____	AGES 40-70 YRS WHO ARE OVERWEIGHT OR OBESE
☐		○	○	○	HEPATITIS-C VIRUS Date of Last:_____	ONCE IF BORN BETWEEN 1945-1965 OR AT HIGH RISK **ORDER ANTI-HCV ANTIBODY TEST; IF (+) ORDER PCR
☐		○	○	○	ASPIRIN PROPHYLAXIS Date of Last:_____	q YR: MALES ≥45 YRS; FEMALES ≥55 YRS OR AT HIGH RISK (HTN, DM, TOBACCO USE, HYPERLIPIDEMIA, KNOWN CVD)
☐		○	○	○	SYPHILIS SCREENING Date of Last:_____	ANNUAL IF AT INCREASED RISK
☐		○	○	○	CHLAMYDIA SCREENING Date of Last:_____	ANNUAL IF AT INCREASED RISK FOR INFECTION AND/OR q YR FOR FEMALES AGE ≤ 24 YRS
☐		○	○	○	GONORRHEA SCREENING Date of Last:_____	ANNUAL IF AT INCREASED RISK FOR INFECTION AND/OR q YR FOR FEMALES AGE ≤ 24 YRS
☐		○	○	○	FOLIC ACID *(Females)* Date of Last:_____	ALL WOMEN PLANNING OR CAPABLE OF PREGNANCY SHOULD TAKE A DAILY SUPPLEMENT CONTAINING 0.4 TO 0.8 MG (400 TO 800 µG) OF FOLIC ACID.
☐		○	○	○	OSTEOPOROSIS (*Females*) Date of Last:_____	BASELINE AT AGE 65 YEARS OR IF AT INCREASED RISK ****PROVIDER DISCRETION AS TO WHAT TEST TO PERFORM****
☐		○	○	○	EKG Date of Last:_____	**AVIATORS ONLY:** q 5 YRS MALE ≥35YRS; FEMALE ≥45YRS

COMMENTS:

SECTION 3C: COUNSELING		
☐ Fitness	☐ Dental	☐ Injury Prevention
☐ Nutrition/Folate	☐ Cancer Prevention	☐ Safe Sex
☐ Family Planning	☐ Present Medications	☐ Mental Health/Stress
☐ Suicide	☐ Hormone/Calcium Replacements	☐ Tobacco
☐ Alcohol/Substance Abuse	☐ Travel	☐ Occupational exposure

SECTION 4 – TO BE COMPLETED BY PROVIDER TEAM

SECTION 4: FURTHER EVALUATION

SECTION 5 – TO BE COMPLETED BY PROVIDER TEAM

SECTION 5: PROVIDER DEMOGRAPHICS		
Clinic Name	Clinic Address	
Clinic Email		
Clinic Phone Number		
Provider Name	Provider Signature	Today's Date (DDMMMYY)