MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

Reserve Component Periodic Health Assessment (RCPHA)

FLYER or NON FLYER **MALE or FEMALE** *(CIRICLE ONE)* **AGE** _____

Assessment *(RCPHA)* **completed:** _____ **DD2766 updated: YES or NO** *(Circle Appropriate)*

Immunization review/current: YES or NO

Dental Class: 1 2 3 4 _____ *(Circle Appropriate)*

RCPHA GRID TESTING REQUIREMENT:

HT:		WT:		HIV:		BP:	/	PULSE:	

PROFILE:

P	U	L	H	E	S	X

Member is QUALIFIED for Worldwide Duty: YES or NO
Member is QUALIFIED for Occupational Duty: YES or NO

Comments:

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)* | REGISTER NO. | WARD NO.

LAST, FIRST, MI:

SSN: