

**MEDICAL RECORD** **CHRONOLOGICAL RECORD OF MEDICAL CARE**  
**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)**

**Reserve Component Periodic Health Assessment (RCPHA)**

FLYER or NON FLYER      MALE or FEMALE      (CIRCLE ONE)      AGE \_\_\_\_\_

Assessment (RCPHA) completed: \_\_\_\_\_ DD 2766 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:	
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DNA: \_\_\_\_\_ Date Accomplished      EKG: YES or NO      EKG Test: Normal or Abnormal  
 Fecal Occult Blood: Positive or Negative      (Circle Appropriate)  
 Skin Exam for Cancer/Surgical Scars: Normal or Abnormal      Other: \_\_\_\_\_  
 Valsalva: NO or YES      Normal and/or Bilateral      Additional Test: (Optional) \_\_\_\_\_

**AUDIOGRAM:**

	500	1000	2000	3000	4000	6000
LEFT						
RIGHT						

Hearing Conservation Program:  
 Reference Audiogram  
 YES or NO  
 (Circle Appropriate)

**VISUAL ACUITY:**

DISTANT				REFLECTIVE				NEAR					
O.D. 20/	Corrected to 20/	by:	S:	CX:	20/	Corrected to 20/	by:	O.D. 20/	Corrected to 20/	by:	S:	CX:	20/
O.D. 20/	Corrected to 20/	by:	S:	CX:	20/	Corrected to 20/	by:	O.D. 20/	Corrected to 20/	by:	S:	CX:	20/

Amsler Grid: O.D. Normal or Abnormal      O.S. Normal or Abnormal      (Circle Appropriate)  
 Contact Lenses: Yes or No      Gas Mask Insert Ordered: Yes or No or N/A      (Circle Appropriate)  
 Intraocular Tension: O.D. \_\_\_\_\_ O.S. \_\_\_\_\_      Glaucoma: Yes or No      (Circle Appropriate)  
 Phorias: RH \_\_\_\_\_ LH \_\_\_\_\_ ES \_\_\_\_\_ EX \_\_\_\_\_      Color Vision: Test Used: \_\_\_\_\_      Pass or Fail

MALE (Circle Appropriate)			FEMALE					
Testicles:	Normal	Abnormal	Pap Smear:	_____	Breast Exam:	_____	Mammogram:	_____
Prostate:	Normal	Abnormal	Date Completed	_____	Date Completed	_____	Date Completed	_____

Member is QUALIFIED for Worldwide Duty: YES or NO      PROFILE:  
 Member is QUALIFIED for Occupational Duty: YES or NO      P U L H E S X

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.