

**Reserve Component Health Risk Assessment (RCHRA)**  
*(This form is subject to the privacy Act of 1974 – Use Blanket PAS – DD Form 2005)*

**AUTHORITY:** 10 U.S.C., 8013, as implemented by Air Force Instruction 48-123.

**PURPOSE:** To collect personal information from military Reserve Component (RC) personnel to assess their ability to perform routine fitness testing, their individual deployment readiness, and overall RC deployment readiness.

**ROUTINE USE(S):** To assess the safety of your performing routine fitness testing. To screen for conditions that may interfere with your ability to deploy and meet mission requirements. To collate data on overall RC capability to deploy and meet mission requirements. In addition to those disclosures generally permitted under 5 USC 552a(b) of the Privacy Act, these records or information contained therein may specifically be disclosed outside DoD as a routine use pursuant to 5 USC 552a(b)(3) as follows: The Department of the Air Force "Blanket Routine Uses" set forth at the beginning of the Air Force's compilation of systems of records notices apply to this system. This information will be kept in your medical record and summary results will be provided to you upon completion of the Reserve Component Periodic Health Assessment (RCPHA).

**DISCLOSURE:** Disclosure of this information is required by Title 10, Chapter 51, Section 1004 of the United States Code. Giving false information concerning current health status is a punishable offense and can result in administrative action. IAW AFI 48-123, paragraph 14.4.2, each member is responsible for promptly reporting a disease, injury, operative procedure or hospitalization not previously reported to his or her commander or supervisor.

**Personnel Data**

Name/Rank		SSN	Age	Date of Birth	Gender
Home Street Address		City	State	Zip Code	
Unit	Duty Section	Base		Duty AFSC	ASC
Primary Email Address			Home Phone	Duty Phone	

Civilian Occupation

<input type="checkbox"/> Active (AGR) Guard/Reserve	<input type="checkbox"/> Traditional Reservist/Guardsman	<input type="checkbox"/> Individual (IMA) Mobilization Augmentee	<input type="checkbox"/> Air Reserve Technician	<input type="checkbox"/> Other Specify
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Traditional ARC: How many days have you performed military duty this year (excluding IDT)? Days

Are you a family member of an active duty military member entitled to care through military channels?  Yes  No

**Racial Background**

<input type="checkbox"/> American Indian/Alaska Native	<input type="checkbox"/> Asian/Oriental	<input type="checkbox"/> Black, Hispanic
<input type="checkbox"/> Black, Non-Hispanic	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> White Hispanic
<input type="checkbox"/> White, Non-Hispanic	<input type="checkbox"/> Other (Specify) <b>OtherSpecify</b>	

**Health Status Questionnaire- Instructions**

Mark the appropriate response to each number question and sign the form after reading it carefully. Continue on the reverse side or attach comments or documentation if necessary. Positive responses which are not fully explained or which may effect your medical qualifications for continued military duty will require an interview and further documentation. You may also be required to provide supporting civilian medical and dental documentation for inclusion in your medical records.

**NOTE:** This information is for official and medically-confidential use only and will not be released to unauthorized persons.

1. Overall Self-Assessment of Health is	<input type="checkbox"/> Excellent	<input type="checkbox"/> Very Good	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
2. Are you on a renewable flying or worldwide duty waiver for any medical reason?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			
3. Do you have any allergies to medications, foods, or airborne substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

List all known allergies:

4. (a) Do you regularly take any prescription medication(s)?										<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
(b) Do you regularly take any over the counter medication(s)?										<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
(c) Do you regularly take any dietary supplement(s)?										<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
<b>Medication(s) Name and why taken</b>																	
5. During the last year have you taken medication or seen a health care provider for any of the following conditions?																	
Chest pain/angina		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Shortness of breath		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Anxiety/depression		<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Inflammatory bowel disease				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Seizure Disorder				<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
If you require medications for any of the above, have the medications been listed in block # 5.										<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
Does the use of these medications control your symptoms? (If No please explain below)										<input type="checkbox"/>	N/A	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No		
6. During the last year have you been told that you have high blood pressure?										<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
7. Since your last AF Form 895, RCPHA, or Physical Examination have you had chest pains, pressure, or discomfort either with physical activity or when at rest?										<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
8. Have you ever had irregular heartbeats that have concerned you?										<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
9. Have you ever had a heart attack?										<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
10. Have you had a heart operation (bypass, angioplasty, etc.)?										<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
11. Is there a family history of heart attack in a parent, sibling, aunt or uncle before the age of 55?										<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
12. Have you been told you have high blood sugar or diabetes? How is it controlled? (Check all that apply.)										<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
<input type="checkbox"/>	Insulin	<input type="checkbox"/>	Diet/Exercise control	<input type="checkbox"/>	Oral Medication	<input type="checkbox"/> Other (Explain)											
13. Have you been told you have problems with blood cholesterol?										<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
14. Do you use any tobacco products? If no, skip to question 15.										<input type="checkbox"/>	Yes	<input type="checkbox"/>	No				
Type- (check all that apply):										<input type="checkbox"/>	Pipe	<input type="checkbox"/>	Cigar	<input type="checkbox"/>	Smokeless	<input type="checkbox"/>	Cigarettes
How many packs of cigarettes per day?					<input type="checkbox"/>	Less than one	<input type="checkbox"/>	One	<input type="checkbox"/>	Two	<input type="checkbox"/>	Three or more					
How many years have you been using tobacco products?					<input type="checkbox"/>	Less than one	<input type="checkbox"/>	One-Five	<input type="checkbox"/>	Six-Ten	<input type="checkbox"/>	More than Ten					

Date	Name/Rank	SSN					
15. Do you ever experience shortness of breath at rest, walking or with only moderate exertion?					Yes	No	
16. Have you ever been told you have asthma, bronchospasm, or reactive airway disease?					Yes	No	
17. Do you engage in a program of regular aerobic physical fitness 20 minutes 3 times per week?					Yes	No	
Light Exercise		Moderate Exercise		Heavy Exercise			
18. Do you have a physical condition that prevents you from brisk walking or running for 1 to 3 miles?					Yes	No	
19. Has your treating physician placed you on restricted activity?					Yes	No	
If yes, explain (include length of time and time of year restrictions apply if known)							
20. Do you have any bone, joint, or muscle problems that prevent regular exercise or become bothersome during exercise?					Yes	No	
21. Are you on any medications for depression, attention deficit, hyperactivity disorder or any other psychiatric condition?					Yes	No	
a. Do you consume alcoholic beverages? <b>If no, skip to question 22.</b>					Yes	No	
b. Have you ever felt you ought to cut down on your drinking?					Yes	No	
c. Have people annoyed you by criticizing your drinking?					Yes	No	
d. Have you ever felt bad or guilty about your drinking?					Yes	No	
e. Have you ever had a drink first thing in the morning (eye opener) to steady your nerves or get rid of a hangover?					Yes	No	
22. Is there a history of cancer in your family? Check all that apply. <input type="checkbox"/> Breast <input type="checkbox"/> Prostate/Testicular <input type="checkbox"/> Colon <input type="checkbox"/> Leukemia <input type="checkbox"/> Other (Explain) <b>Explanation Other Cancer HIs</b>						No	
23. Do you wear prescription glasses or contact lenses? Check all that apply below.					Yes	No	
Blurred Vision		Double Vision		Blind Spots		Night Blindness	
Glare		Glaucoma		Glasses more than 2 years old			
24. Have you had any of the following types of eye surgery (check all that apply)?					Yes	No	
RK	PRK	LASIK	Implants	Other Specify:			
25. Have you gained or lost more than 15 pounds in the past year that cannot be explained by change in diet and exercise?					Yes	No	
26. Have you noticed blood in your stool or significant changes in your bowel habits?					Yes	No	
27. Have you been advised to eat a special diet?					Yes	No	
28. During the past year have you missed more than 7 days from work due to illness or injury?					Yes	No	
29. Do you have a non-military job or hobby which exposes you to loud noise?					Yes	No	
30. Do you have a non-military job or hobby which exposes you to hazardous chemicals?					Yes	No	

Name and/or type of chemical(s)?										
31. Do you use hearing aid(s)?								Yes		No
32. Do you routinely forget to wear proper protective gear for sports, hobbies, or work (e.g., helmets, goggles, ear plugs, gloves, etc.)?								Yes		No
33. Do you routinely forget to fasten your seat belt?								Yes		No
34. Have you seen a health care provider during this past year?								Yes		No
If yes how many visits:		One - Two	Three - Six	Seven - Ten	More than Ten					
35. Excluding pregnancy have you been a patient in the hospital overnight/or had any outpatient surgical procedure or been administered intravenous medication in the hospital during the past year?								Yes		No
36. Have you been treated for any other medical conditions since you completed your last RCPHA or AF Form 895? Please list conditions below.								Yes		No
<b>Females Only Complete Blocks 37 - 41</b>										
37. Are you pregnant?								Yes		No
38. Was your last PAP Smear abnormal?								Yes		No
39. Have you ever had an abnormal breast lump or mammogram?								Yes		No
40. Do you perform self-breast examination (SBE) at least monthly?								Yes		No
41. If no longer having menstrual periods or had a total hysterectomy, have you been advised regarding osteoporosis prevention?								Yes		No
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Typed or Printed Name Examinee					Signature			Date		
Notes:										
Typed or Printed Name Physician or Examiner					Signature			Date		