U.S. DEPARTMENT OF HOMELAND SECURITY
U.S. COAST GUARD
CG-6150 Rev. 02-09

U.S. COAST GUARD PERIODIC HEALTH ASSESSMENT

Patient Name *(Last, First, MI)*	SSN	DOB	Date

SECTION 1: VITALS

Height *(inches)*

Weight *(pounds)*

BMI

Temperature

Respirations

Blood Pressure
_____ / _____
_____ / _____
☐ Treated ☐ Untreated

Pulse

Vital Signs Noted
Remarkable for:
☐ None
☐ Other: _____
_____
_____

_____ year old ☐ male ☐ female reports for an annual Periodic Health Assessment (PHA) which includes record review/verification, assessment and counseling of avoidable health risk factors, clinical preventive services (CPS) recommendations, deployment/operational health history, and individual medical readiness (IMR) assessment.

SECTION 5: HEALTHCARE PROVIDER ASSESSMENT

1. Updated DD 2766 Sections *(check)*: ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7
2. Does Member smoke? ☐ Yes ☐ No
3. Health Risk Assessment reviewed: Health Risk Assessment Level: ☐ High ☐ Medium ☐ Low
4. Referred for consultation/follow-up on: ☐ N/A ☐ Tobacco Use ☐ Physical Activity ☐ ETOH Use ☐ Nutrition ☐ Mental Health ☐ Other:
5. Clinical Preventive Services recommended: ☐ N/A ☐ Pap ☐ Chlamydia ☐ Mammogram ☐ Clinical Breast Exam ☐ Colorectal ☐ Prostate ☐ Cholesterol ☐ Testicular Exam
6. Referred to PCM for: ☐ N/A ☐ Current Medications ☐ Chronic Medical Condition ☐ Current Illness/Injury ☐ Fitness for Duty Issue ☐ Weight Problem Clearance ☐ Other:
7. Has Member ever tested positive for TB? ☐ Yes ☐ No
   If Yes: ☐ Asymptomatic ☐ Symptomatic
   List symptoms:
8. Pain Level *(zero pain to severe):* ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
   Location:
9. Any unresolved operational or deployment health issues? ☐ Yes ☐ No
   If Yes, explain:
10. Other health concerns?
    ☐ No health issues identified requiring a focused exam ☐ Focused exam required for *(document on separate SF600)*

SECTION 2: IME VERIFICATION

Prescription Lenses *(two pair)*
☐ Yes ☐ No ☐ NA

Ballistic Eyewear
☐ Yes ☐ No ☐ NA

Gas Mask Inserts
☐ Yes ☐ No ☐ NA

Medical Alert Tags
☐ Yes ☐ No ☐ NA

SECTION 6: DUTY STATUS ASSESSMENT

On Limited Duty ☐ Yes ☐ No Medical Board Pending ☐ Yes ☐ No Waivers ☐ Yes ☐ No

Comments for Yes:

Additional Comments:

SECTION 3: VISION

Visual Acuity Corrected:
OD _____
OS _____
Binocular _____

Visual Acuity Uncorrected:
OD _____
OS _____
Binocular _____

Member informed that completion of recommended test/immunizations/screening shall be performed within the next 30 days and he/she is personally responsible for achieving/maintaining individual readiness. Member received health risk prevention/health lifestyle counseling and voiced understanding.

_____ X_____
Member Name *(print)* Member Signature Date

_____ X_____
Provider Name & Credentials *(print)* Provider Signature Date
** Must be performed by MD, DO, PA, NP*

SECTION 4: AUDIO

Finger Rub Test:
Left ☐ Pass ☐ Fail
Right ☐ Pass ☐ Fail

RHRP USE ONLY

1. Total Cholesterol _____ HDL _____
2. Cardiovascular Screening *(Framingham 10-year risk if over 40 y/o)* _____
3. Member readiness reviewed and updated in approved electronic data system. Member is fully medically ready and requires no follow-up at this time. ☐ Yes ☐ No
4. Additional Comments:

Reset