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
ARPC	**GME**	**Buckley AFB, CO**	**44X/45X**	**NA**

Primary Email Address	Home Phone	Duty Phone

Civilian Occupation

☐ Active *(AGR)* Guard/Reserve	☐ Traditional Reservist/Guardsman	☐ Individual *(IMA)* Mobilization Augmentee	☐ Air Reserve Technician	✔ Other Specify **IRR GME**

Traditional ARC: How many days have you performed military duty this year *(excluding IDT)*? **NA** Days

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

Racial Background

☐ American Indian/Alaska Native	☐ Asian/Oriental	☐ Black, Hispanic
☐ Black, Non-Hispanic	☐ Pacific Islander	☐ White Hispanic
☐ White, Non-Hispanic	☐ Other *(Specify)* **OtherSpecify**	

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 ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

2. Are you on a renewable flying or worldwide duty waiver for any medical reason? ☐ Yes ☐ No

3. Do you have any allergies to medications, foods, or airborne substances? ☐ Yes ☐ No

List all known allergies:

4. (a) Do you regularly take any prescription medication*(s)*?	☐	Yes	☐	No
(b) Do you regularly take any over the counter medication*(s)*?	☐	Yes	☐	No
(c) Do you regularly take any dietary supplement*(s)*?	☐	Yes	☐	No

Medication*(s)* Name and why taken

5. During the last year have you taken medication or seen a health care provider for any of the following conditions?

Chest pain/angina	☐	Yes	☐	No	Shortness of breath	☐	Yes	☐	No	Anxiety/depression	☐	Yes	☐	No
Inflammatory bowel disease	☐	Yes	☐	No	Seizure Disorder						☐	Yes	☐	No
If you require medications for any of the above, have the medications been listed in block # 5.											☐	Yes	☐	No
Does the use of these medications control your symptoms? *(If No please explain below)*	☐	N/A									☐	Yes	☐	No

6. During the last year have you been told that you have high blood pressure?	☐	Yes	☐	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?	☐	Yes	☐	No
8. Have you ever had irregular heartbeats that have concerned you?	☐	Yes	☐	No
9. Have you ever had a heart attack?	☐	Yes	☐	No
10. Have you had a heart operation *(bypass, angioplasty, etc.)*?	☐	Yes	☐	No
11. Is there a family history of heart attack in a parent, sibling, aunt or uncle before the age of 55?	☐	Yes	☐	No
12. Have you been told you have high blood sugar or diabetes? How is it controlled? *(Check all that apply.)*	☐	Yes	☐	No

☐ ☐ Insulin ☐ Diet/Exercise control ☐ Oral Medication ☐ Other (Explain)

13. Have you been told you have problems with blood cholesterol?	☐	Yes	☐	No
14. Do you use any tobacco products? If no, skip to question 15.	☐	Yes	☐	No

Type- (check all that apply): ☐ Pipe ☐ Cigar ☐ Smokeless ☐ Cigarettes

How many packs of cigarettes per day?	☐	Less than one	☐	One	☐	Two	☐ Three or more
How many years have you been using tobacco products?	☐	Less than one	☐	One-Five	☐	Six-Ten	☐ 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? **If no, skip to question 22**. [ ] 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. [ ] Breast [ ] Prostate/Testicular [ ] Colon [ ] Leukemia [ ] Other (Explain) **Explanation Other Cancer HIs** [ ] 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

Females Only Complete Blocks 37 – 41

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
NOT REQUIRED	**NOT REQUIRED**	**N/A**