

# POST-DEPLOYMENT

# Health Assessment

33348

Authority: 10 U.S.C. 136 Chapter 55. 1074f, 3013, 5013, 8013 and E.O. 9397

Principal Purpose: To assess your state of health after deployment outside the United States in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care to you.

Routine Use: To other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment.

Disclosure: (Military personnel and DoD civilian Employees Only) Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before marking your selections. Provide a response for each question. If you do not understand the question, ask the administrator.

## Demographics

### Last Name

### First Name

### MI

### Name of Your Unit or Ship during this Deployment

### Gender

- Male
- Female

### Service Branch

- Air Force
- Army
- Coast Guard
- Marine Corps
- Navy
- Other

### Component

- Active Duty
- National Guard
- Reserves
- Civilian Government Employee

### Location of Operation

- Europe
- SW Asia
- SE Asia
- Asia (Other)
- Australia
- Africa
- Central America
- Unknown
- South America
- North America
- Other \_\_\_\_\_

### To what areas were you mainly deployed:

(mark all that apply - list where/date arrived)

- Kuwait \_\_\_\_\_
- Qatar \_\_\_\_\_
- Afghanistan \_\_\_\_\_
- Bosnia \_\_\_\_\_
- On a ship \_\_\_\_\_

- Iraq \_\_\_\_\_
- Turkey \_\_\_\_\_
- Uzbekistan \_\_\_\_\_
- Kosovo \_\_\_\_\_
- CONUS \_\_\_\_\_
- Other \_\_\_\_\_

### Name of Operation:

### Occupational specialty during this deployment

(MOS, NEC or AFSC)

Combat specialty: \_\_\_\_\_

### Today's Date (dd/mm/yyyy)

### Social Security Number

### DOB (dd/mm/yyyy)

### Date of arrival in theater (dd/mm/yyyy)

### Date of departure from theater (dd/mm/yyyy)

### Pay Grade

- E1
- E2
- E3
- E4
- E5
- E6
- E7
- E8
- E9
- O1
- O2
- O3
- O4
- O5
- O6
- O7
- O8
- O9
- O10
- W1
- W2
- W3
- W4
- W5
- Other

### Administrator Use Only

Indicate the status of each of the following:

- | Yes                   | No                    | N/A                   |  |
|-----------------------|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Medical threat debriefing completed      |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Medical information sheet distributed    |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Post-Deployment serum specimen collected |

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# Please answer all questions in relation to THIS deployment

## 1. Did your health change during this deployment?

- Health stayed about the same or got better
- Health got worse

## 2. How many times were you seen in sick call during this deployment?

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No. of times

## 3. Did you have to spend one or more nights in a hospital as a patient during this deployment?

- No
- Yes, reason/dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 4. Did you receive any vaccinations just before or during this deployment?

- Smallpox (leaves a scar on the arm)
- Anthrax
- Botulism
- Typhoid
- Meningococcal
- Other, list: \_\_\_\_\_
- Don't know
- None

## 5. Did you take any of the following medications during this deployment?

(mark all that apply)

- PB (pyridostigmine bromide) nerve agent pill
- Mark-1 antidote kit
- Anti-malaria pills
- Pills to stay awake, such as dexedrine
- Other, please list \_\_\_\_\_
- Don't know

## 6. Do you have any of these symptoms now or did you develop them anytime during this deployment?

<u>No</u>	<u>Yes During</u>	<u>Yes Now</u>		<u>No</u>	<u>Yes During</u>	<u>Yes Now</u>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Chronic cough
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Chest pain or pressure
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dizziness, fainting, light headedness
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Difficuly breathing
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Still feeling tired after sleeping
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Difficuly remembering
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diarrhea
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Frequent indigestion
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Vomiting
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Ringng of the ears
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Swollen, stiff or painful joints
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Headaches
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Back pain
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Muscle aches
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Numbness or tingling in hands or feet
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Skin diseases or rashes
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Redness of eyes with tearing
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dimming of vision, like the lights were going out

## 7. Did you see anyone wounded, killed or dead during this deployment?

(mark all that apply)

- No
- Yes-coalition
- Yes-enemy
- Yes-civilian

## 8. Were you engaged in direct combat where you discharged your weapon?

- No
- Yes (  land  sea  air )

## 9. During this deployment, did you ever feel that you were in great danger of being killed?

- No
- Yes

## 10. Are you currently interested in receiving help for a stress, emotional, alcohol, or family problem?

- No
- Yes

## 11. Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?

<u>None</u>	<u>Some</u>	<u>A Lot</u>	
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Little interest or pleasure in doing things
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Feeling down, depressed, or hopeless
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Thoughts that you would be better off dead or hurting yourself in some way

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**12. Have you ever had any experience that was so frightening, horrible, or upsetting that, IN THE PAST MONTH, you...**

- | <u>No</u>             | <u>Yes</u>            |   |
|-----------------------|-----------------------|---|
| <input type="radio"/> | <input type="radio"/> | Have had any nightmares about it or thought about it when you did not want to?                      |
| <input type="radio"/> | <input type="radio"/> | Tried hard not to think about it or went out of your way to avoid situations that remind you of it? |
| <input type="radio"/> | <input type="radio"/> | Were constantly on guard, watchful, or easily startled?   |
| <input type="radio"/> | <input type="radio"/> | Felt numb or detached from others, activities, or your surroundings?                                |

**13. Are you having thoughts or concerns that...**

- | <u>No</u>             | <u>Yes</u>            | <u>Unsure</u>         |  |
|-----------------------|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | You may have serious conflicts with your spouse, family members, or close friends? |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | You might hurt or lose control with someone?                                       |

**14. While you were deployed, were you exposed to:**  
(mark all that apply)

- | <u>No</u>             | <u>Sometimes</u>      | <u>Often</u>          |  |
|-----------------------|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | DEET insect repellent applied to skin        |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Pesticide-treated uniforms                   |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Environmental pesticides (like area fogging) |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Flea or tick collars                         |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Pesticide strips                             |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Smoke from oil fire                          |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Smoke from burning trash or feces            |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Vehicle or truck exhaust fumes               |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Tent heater smoke                            |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | JP8 or other fuels                           |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Fog oils (smoke screen)                      |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Solvents                                     |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Paints                                       |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Ionizing radiation                           |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Radar/microwaves                             |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Lasers                                       |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Loud noises                                  |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Excessive vibration                          |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Industrial pollution                         |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Sand/dust                                    |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Depleted uranium (if yes, explain)_____      |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Other exposures                              |

**15. On how many days did you wear your MOPP over garments?**

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No. of days

**16. How many times did you put on your gas mask because of alerts and NOT because of exercises?**

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No. of times

**17. Were you in or did you enter or closely inspect any destroyed military vehicles?**

- No       Yes

**18. Do you think you were exposed to any chemical, biological, or radiological warfare agents during this deployment?**

- No                       Don't know  
 Yes, explain with date and location

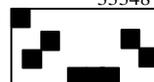
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Health Care Provider Only

SERVICE MEMBER'S SOCIAL SECURITY#

Grid for Social Security Number: [ ][ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ][ ]

Post-Deployment Health Care Provider Review, Interview, and Assessment

Interview

- 1. Would you say your current health in general is: [ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor
2. Do you have any medical or dental problems that developed during this deployment? [ ] Yes [ ] No
3. Are you currently on a profile or light duty? [ ] Yes [ ] No
4. During this deployment have you sought, or do you now intend to seek, counseling or care for your mental health? [ ] Yes [ ] No
5. Do you have concerns about possible exposures or events during this deployment that you feel may affect your health? [ ] Yes [ ] No
Please list concerns: \_\_\_\_\_
6. Do you currently have any questions or concerns about your health? [ ] Yes [ ] No
Please list concerns: \_\_\_\_\_

Health Assessment

After my interview/exam of the service member and review of this form, there is a need for further evaluation as indicated below. (More than one may be noted for patients with multiple problems. Further documentation of the problem evaluation to be placed in the service member's medical record.)

REFERRAL INDICATED FOR:

- [ ] None
[ ] Cardiac
[ ] Combat / Operational Stress Reaction
[ ] Dental
[ ] Dermatologic
[ ] ENT
[ ] Eye
[ ] Family Problems
[ ] Fatigue, Malaise, Multi-system complaint
[ ] Audiology

- [ ] GI
[ ] GU
[ ] GYN
[ ] Mental Health
[ ] Neurologic
[ ] Orthopedic
[ ] Pregnancy
[ ] Pulmonary
[ ] Other \_\_\_\_\_

EXPOSURE CONCERNS (During deployment):

- [ ] Environmental
[ ] Occupational
[ ] Combat or mission related
[ ] None

Comments: \_\_\_\_\_

I certify that this review process has been completed.
Provider's signature and stamp:

Signature box

This visit is coded by V70.5 \_\_ 6

Date (dd/mm/yyyy) [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

End of Health Review

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