

SEPARATION HEALTH ASSESSMENT - PART A SELF-ASSESSMENT

PRIVACY ACT STATEMENT

This statement serves to inform you, as required by the Privacy Act of 1974, as amended, of the purpose for collecting personal information and how that information will be stored and used.

AUTHORITY: Title 10, United States Code (U.S.C.) § 1145, Health Benefits; Department of Defense (DoD) Instruction 6040.46, "Separation History and Physical Examination for DoD Separation Health Assessment Program"; 5 U.S.C. § 301, Departmental Regulations; 10 U.S.C. § 136, Under Secretary of Defense for Personnel and Readiness; Public Law 104-191, Health Insurance Portability and Accountability Act (HIPAA) of 1996; 10 U.S.C., Chapter 55, Medical and Dental Care; DoD Manual 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs"; and Executive Order 9397 (relating to Federal agency use of Social Security Numbers), as amended.

PURPOSE: The information collected is used to assist the DoD and/or Department of Veterans Affairs (VA) examiners in assessing the health and wellness status of individuals separating from active duty as well as to determine disqualifying medical condition(s) for medical retention and/or compensation.

ROUTINE USES: These records may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. § 552a(b)(3) as follows: to contractors and others performing or working for the Federal Government when necessary to accomplish an agency function related to this System of Records; to the Department of Health and Human Services, other Federal agencies, and academic institutions for the purposes of public health activities and conducting research; and to the VA for the purpose of providing medical care, to determine the eligibility for benefits, to coordinate cost sharing activities, and to facilitate collaborative research activities between DoD and VA.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Rules, as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary. If you choose not to provide the requested information, there may be an administrative delay; however, no penalty may be imposed.

PART A - SERVICE MEMBER IDENTIFICATION AND SELF-ASSESSMENT

SECTION I - IDENTIFICATION

NOTE TO THE SERVICE MEMBER: Please complete the following subsections.

IDENTIFIER

#	Question	Response
1	Name	
2	SSN (<i>Social Security Number</i>)	
3	DoD ID Number	
4	Today's Date (<i>self-assessment date</i>)	(YYYYMMDD)

1. CONTACT INFORMATION

#	Question	Response
1	Current Address	
2	Work Telephone Number	
3	Personal Telephone Number	
4	Government Email	
5	Personal Email	
6	Preferred method of contact	<input type="checkbox"/> Mail <input type="checkbox"/> Work Phone <input type="checkbox"/> Personal Phone <input type="checkbox"/> Government Email <input type="checkbox"/> Personal Email

2. PERSONAL INFORMATION

#	Question	Response
1	Date of Birth (<i>DoB</i>)	(YYYYMMDD)
2	Age	
3	Ethnicity	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino
4	Race (<i>mark all that apply</i>)	<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Unknown <input type="checkbox"/> Black or African American <input type="checkbox"/> Choose not to answer <input type="checkbox"/> White

CUI (when filled in)

NAME		DOD ID NUMBER	
5	Birth Gender (<i>biological sex</i>)	<input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Non-binary
6	Gender Identity	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Transgender male (<i>Female to Male</i>)	<input type="checkbox"/> Transgender female (<i>Male to Female</i>) <input type="checkbox"/> Other: _____ <input type="checkbox"/> Choose not to answer
7	Administrative Gender (<i>gender identified on official military records</i>)	<input type="checkbox"/> Female	<input type="checkbox"/> Male

3. OCCUPATIONAL INFORMATION

#	Question	Response	
1	Service	<input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Air Force	<input type="checkbox"/> Space Force <input type="checkbox"/> Coast Guard <input type="checkbox"/> Other: _____
2	Component	<input type="checkbox"/> Active Duty	<input type="checkbox"/> Reserve <input type="checkbox"/> National Guard
3	Duty Status	<input type="checkbox"/> Active Component <input type="checkbox"/> Active Duty – non AGR	<input type="checkbox"/> Active Duty – AGR <input type="checkbox"/> Not on active duty
4	Usual Occupation (<i>most recent day-to-day job</i>)		
5	What is your military occupational code (<i>for example: MOS, AOC, AFSC, NEC, or Designator Code</i>)?		

4. EXAMINATION INFORMATION

#	Question	Response
1	Exam Date (<i>if known</i>)	(YYYYMMDD)
2	Purpose of Exam	<input type="checkbox"/> Separation from period of active service <input type="checkbox"/> Retirement <input type="checkbox"/> Separation from military service <input type="checkbox"/> Other: _____ <input type="checkbox"/> Medical Board
3	Provide date or anticipated date of release from Active Duty	(YYYYMMDD)
4	Do you intend to file a claim, or have you already filed a claim, for disability compensation with the Veterans Benefits Administration?	<input type="checkbox"/> Yes <input type="checkbox"/> No (<i>if no, skip to question 6</i>)
5	Select the type of claim program/process	<input type="checkbox"/> Fully Developed Claim (FDC) Program <input type="checkbox"/> IDES (Integrated Disability Evaluation System) (<i>select this option only if you have been referred to IDES by your Military Service</i>) <input type="checkbox"/> BDD (Benefits Delivery at Discharge) (<i>select this option only if you meet the criteria for the BDD program</i>) <input type="checkbox"/> Standard Claim Process <input type="checkbox"/> Not sure
6	Have you ever filed a disability claim with the VA?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Have you had a physical exam within 12 months before your separation date?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure (<i>if no or unsure, skip to Section II</i>)
	Date of exam	(YYYYMM)
	Type of exam (<i>for example: School, Flight, Special Duty</i>)	
	Would you like that exam reviewed to determine if it is sufficient to meet the separation health assessment requirements?	<input type="checkbox"/> Yes <input type="checkbox"/> No

NAME	DOD ID NUMBER
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SECTION II - REPORT OF MEDICAL HISTORY

Please complete all information in the following medical history questionnaire before your appointment for a Separation Health Assessment (SHA) Clinical Assessment. Your responses will help us understand your current health status and wellness. For each response, briefly describe the history, including dates, as indicated and applicable. If you are submitting a VA claim, then an appropriate evaluation, to include examinations and completion of any necessary Disability Benefits Questionnaires (DBQs), will be completed at a later date in order to ensure that the available information is sufficient for rating purposes.

Note: "Qualifying military service" includes: active duty; on orders 30 days or more in support of contingency operation(s); on continuous active duty orders for 180 days or more. This includes active duty, any period of active duty for training, and any period of inactive duty.

1. GENERAL MEDICAL REVIEW

#	Question	Response
1	List your current medications, including supplements.	
2	Date of your most recent military service medical assessment/physical exam	(YYYYMMDD)
	Compared to your last military service medical assessment/physical exam, your overall health is:	<input type="checkbox"/> The Same <input type="checkbox"/> Better <input type="checkbox"/> Worse If better or worse, explain:
3	Overall, how would you rate your health during the PAST MONTH?	<input type="checkbox"/> The Same <input type="checkbox"/> Better <input type="checkbox"/> Worse If better or worse, explain:
	During the PAST MONTH, did you have physical health problems (<i>illness or injury</i>) that made it difficult for you to do your work or other regular daily activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
5	Do you currently require hearing aids, special medical supplies, Continuous Positive Airway Pressure (CPAP), adaptive equipment, assistive technology devices, and/or other special accommodations?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
	Have you had any surgery since your last health assessment/exam? (<i>Include privately paid elective surgeries.</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
7	Since your last health assessment/exam, has a health care provider recommended surgery(s) that you have not had (<i>whether you are planning to have it or not</i>)?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
	Since your last health assessment/exam, have you received care or treatment for any medical and/or mental health condition(s) from a CIVILIAN or NON-MILITARY facility? This includes privately paid treatments and/or procedures (<i>for example: photorefractive keratectomy (PRK), wisdom teeth removal, vasectomy, botox.</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
9	Have you suffered from any injury or illness while on active duty for which you did not seek medical care (<i>to include mental health</i>)?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
	During qualifying military service, have you ever experienced:	
10	Allergies, including environmental and occupational allergies, and adverse reaction to serum, food, insect stings, or medicine.	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
	High or bad cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

CUI (when filled in)

NAME		DOD ID NUMBER
12	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
13	Coughing up blood	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
14	Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
15	Bronchitis	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
16	Chronic cough or cough at night	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
17	Wheezing, shortness of breath, or difficulty breathing <i>(other than asthma)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
18	Other lung problems <i>(for example: Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, pneumonia, emphysema)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
19	Sinusitis	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
20	Thyroid trouble or goiter	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
21	Ear, nose, or throat trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
22	Frequent indigestion or heartburn <i>(reflux)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
23	Stomach or intestinal problems <i>(for example: ulcer)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

CUI (when filled in)

NAME		DOD ID NUMBER
24	Kidney problems <i>(for example: stones, infection)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
25	Liver problems <i>(for example: hepatitis, cirrhosis)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
26	Constipation, loose bowels, or diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
27	Gallbladder trouble or gallstones	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
28	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
29	Rectal disease, hemorrhoids, or blood from rectum	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
30	Frequent or painful urination or blood in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
31	High or low blood sugar	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
32	Sugar or protein in urine	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
33	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
34	Recent unexplained gain or loss of weight	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
35	A head injury, memory loss, or amnesia	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

CUI (when filled in)

NAME		DOD ID NUMBER
36	Recurring headaches/ migraines; frequent or severe headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
37	Periods of dizziness, fainting, or loss of consciousness	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
38	Mental health problems (for example: depression, anxiety, Post-Traumatic Stress Disorder (PTSD), worry, or other mental health diagnosis)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
39	Neurological problems (for example: stroke, seizures, convulsions, epilepsy, fits, tremor)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
40	Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
41	Meningitis, encephalitis, or other neurological infection or disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
42	Rheumatic fever	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
43	Prolonged bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
44	Blood problems (for example: hemophilia, sickle cell disease)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
45	Immune system problems (for example: HIV, chemotherapy, radiation)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
46	Angina, also called angina pectoris	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
47	Congestive Heart Failure	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
48	Pain, pressure, or discomfort in your chest	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

CUI (when filled in)

NAME		DOD ID NUMBER
49	Palpitations, pounding heart, or abnormal heartbeat	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
50	Heart murmur or valve problem (<i>for example: mitral valve prolapse</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
51	Coronary heart disease	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
52	Heart attack (<i>also called myocardial infarction</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
53	High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
54	Low blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
55	Skin diseases (<i>other than cancer</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
56	Cancer (<i>other than skin</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
57	Skin cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

2. JOINT, SPINE, & MUSCULO-SKELETAL SYSTEM

#	Question	Response
During qualifying military service, have you ever experienced pain and/or injury in the following:		
1	Head and Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
2	Back and Chest	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
3	Shoulder/Arm	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

CUI (when filled in)

NAME		DOD ID NUMBER
4	Elbow/Forearm	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
5	Wrist/Hand/Fingers	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
6	Hip/Thigh	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
7	Leg/Knee	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
8	Ankle/Foot/Toes	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

3. HEALTH & WELLNESS

#	Question	Response
1	Do you currently use tobacco products (<i>cigarettes, cigars, pipes, etc.</i>), electronic nicotine products (<i>e-cigarette/JUUL, e-hookah, vape-pen, vaporizer, tank system, other similar nicotine products</i>), smokeless tobacco products (<i>chewing tobacco, snuff, dip, snus (pronounced as "snoose"), or dissolvable tobacco</i>)?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
2	Have you smoked at least 100 cigarettes in your entire life? (<i>Note: A pack typically contains 20 cigarettes</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, skip to question 5.
3	During the past 12 months, have you ever tried to stop smoking?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
4	Have you ever had a serious health problem that was caused or made worse by smoking?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
5	During the past 12 months, how often were you exposed to secondhand smoke indoors (<i>home, work, vehicle, etc.</i>), a mixture of smoke that comes from the burning end of a tobacco product (<i>cigarettes, cigars, pipes, etc.</i>), or vapor indoors from a person using an e-cigarette/JUUL, e-hookah, vape-pen, vaporizer, tank system, or other similar nicotine product?	<input type="checkbox"/> Daily <input type="checkbox"/> Less than daily <input type="checkbox"/> Not at all
6	Do you have any concerns with past use of recreational drugs or misuse of prescription drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

4. HEARING

#	Question	Response
1	During qualifying military service have you ever had, or do you now have, persistent or recurring noises in your head or ears? (<i>for example: ringing, buzzing, humming</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

CUI (when filled in)

NAME	DOD ID NUMBER	
2	During qualifying military service have you ever had, or do you now have, a change in your hearing that impacts duty performance?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
3	Do you currently, or have you ever worn, a hearing aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
4	During your deployment or during military training, were you exposed to loud noises, to include blasts, that resulted in a temporary or permanent decrease in hearing and/or ringing, humming, buzzing sounds in your ears or head?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times? For how long? Describe exposure and any symptoms you are still experiencing.

5. VISION

#	Question	Response
1	Do you wear corrective lenses (<i>glasses or contacts</i>)?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

During qualifying military service, have you ever experienced:

2	Eye disorder or trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
3	Surgery to correct vision	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
4	Loss of vision in either eye	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
5	Double vision (<i>diplopia</i>)	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
6	Change in your vision that impacts your duty performance	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

6. HEAD INJURY

#	Question	Response
During qualifying military service:		
1	As a result of any injury or event, did you receive a jolt or blow to your head that IMMEDIATELY resulted in:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable If yes, check all that apply: <input type="checkbox"/> Losing consciousness (" <i>knocked out</i> ")? <input type="checkbox"/> Losing memory of events before or after the injury? <input type="checkbox"/> Seeing stars, becoming disoriented, functioning differently, or nearly blacking out?
2	How many total times did you receive a jolt or blow to your head?	

CUI (when filled in)

NAME		DOD ID NUMBER
3	Have you ever experienced a head injury, concussion, or Traumatic Brain Injury (TBI)?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
4	As a result of any injury or event, where you received a jolt or blow to your head, or were diagnosed with a TBI:	
	Have you had prolonged symptoms that have not resolved?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
	Are you currently experiencing any prolonged symptoms that have not resolved?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

7. ENVIRONMENTAL/OCCUPATIONAL

This section covers various potentially hazardous occupational and environmental exposures during qualifying military service. Exposures may have occurred while deployed, in training, or during other assignments. Consider your potential exposure to: burn pits, oil well fires, burning trash, dust storms, air pollution, explosions, fuels/fumes, pesticides/insecticides, cleaning agents, solvents, heavy metals/depleted uranium, nerve agents/gases, protective medication and vaccines (for example: *Pyridostigmine Bromide (PB)*, *Lariam (Mefloquine) pills*), persistent chemicals such as PCBs, asbestos, radiation, unusual food/drinking water exposures, contaminated water, and personal hygiene exposures (for example: *swimming, showering, etc.*).

#	Question	Response
1	Were you potentially exposed to any occupational/ environmental hazards (described above) while in a qualifying military duty service?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If yes or unsure, provide details here:
2	Have you been based or stationed at a location where an open burn pit was used?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If yes or unsure, provide details here:
3	Have you been potentially exposed to toxic airborne chemicals or other airborne contaminants?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If yes or unsure, provide details here:
4	If 2 or 3 is "Yes" or "Unsure," have you enrolled in the Airborne Hazards and Open Burn Pit Registry?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable
5	Federal law requires eligible members to enroll in the Airborne Hazards and Open Burn Pit Registry or to opt-out. If eligible choose one: (See below for more information on the registry.)	I wish to: <input type="checkbox"/> enroll <input type="checkbox"/> opt out <input type="checkbox"/> Not Applicable
6	While deployed, were you potentially exposed to other deployment-related hazards?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure If yes or unsure, provide details here:
7	During any part of your qualifying military service, were you exposed to any of the following? (check all that apply)	<input type="checkbox"/> Medications to prevent malaria/ malaria prophylaxis, including Mefloquine <input type="checkbox"/> A vaccine with a possible complication <input type="checkbox"/> Firefighting foam <input type="checkbox"/> Solvents or other chemicals that may have caused skin reactions, breathing problems, or other concerns <input type="checkbox"/> Fuels <input type="checkbox"/> Contaminated water <input type="checkbox"/> Radiation (include any possible exposure to depleted uranium) <input type="checkbox"/> Other exposures of possible concern not listed here <input type="checkbox"/> Embedded shrapnel <input type="checkbox"/> Unsure

NAME		DOD ID NUMBER
8	If you checked any exposures, including "unsure," listed in question 7, please explain your exposure concerns in the right column, being as specific as possible.	Provide details of exposure concerns here:
9	Are you currently participating in any specialty occupational exposure examinations?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
During qualifying military service, have you ever experienced:		
10	A blast or explosion?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
11	A vehicular accident/crash (any vehicle including aircraft)?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
12	A fragment wound or bullet wound?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

The Airborne Hazards and Open Burn Pit Registry

Are you eligible to participate? AHOBPR is open to Service members and Veterans who deployed to contingency operations in the Southwest Asia theater of operations at any time on or after August 2, 1990, or Afghanistan or Djibouti on or after September 11, 2001. These regions include the following countries, bodies of water, and the airspace above these locations: Iraq, Afghanistan, Kuwait, Saudi Arabia, Bahrain, Djibouti, Gulf of Aden, Gulf of Oman, Oman, Qatar, and the United Arab Emirates; and waters of the Persian Gulf, Arabian Sea, Red Sea, Uzbekistan, and Syria. The VA will use deployment data provided by DoD to determine your eligibility. You can join the AHOBPR even if:

- You do not think you were exposed to specific airborne hazards.
- You are not experiencing symptoms or illnesses you think are related to exposures.
- You have not filed a VA claim for compensation benefits or applied for VA health care.
- You are still an active duty Service member, reservist, or have returned to active service.

Visit www.publichealth.VA.gov/airbornehazards to learn more about airborne hazards and the AHOBPR.

If you are not eligible for the AHOBPR but are concerned about your exposures, you can still apply for VA health care and file a claim for compensation and benefits.

8. DENTAL

#	Question	Response
1	Do you currently have any dental problems that need to be evaluated?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
2	Have you ever been diagnosed or treated for oral cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

During qualifying military service, have you ever experienced:

3	A dental examination where you were told you had a Temporomandibular Disorder (TMD) or Temporomandibular Joint (TMJ) problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
4	Your jaw locked open and you could not close the jaw?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:
5	Loss of a portion of the bone in your upper or lower jaw due to trauma or disease such as osteomyelitis or necrosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:

CUI (when filled in)

NAME		DOD ID NUMBER						
6	Loss of any teeth because of service-related trauma?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:						
7	Physical (<i>anatomical</i>) loss or injury to your mouth, lips, or tongue?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:						
9. WOMEN'S HEALTH / FEMALE REPRODUCTIVE ORGANS		<input type="checkbox"/> Not Applicable						
#	Question	Response						
During qualifying military service, have you ever:								
1	Been diagnosed with and/or treated for any of the following disorders? (<i>check all that apply</i>)	<input type="checkbox"/> Fibroids (<i>leiomyomas</i>) <input type="checkbox"/> Endometriosis Date (YYYYMMDD): _____ Diagnosed by laparoscopy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Rectocele or cystocele <input type="checkbox"/> Polycystic Ovarian Syndrome (<i>PCOS</i>) <input type="checkbox"/> Infertility/difficulty getting pregnant			<input type="checkbox"/> Recurrent miscarriage (<i>2 or more pregnancy losses</i>) <input type="checkbox"/> Ovarian cancer <input type="checkbox"/> Cervical cancer <input type="checkbox"/> Uterine/endometrial cancer <input type="checkbox"/> Breast cancer <input type="checkbox"/> Bone loss or osteoporosis <input type="checkbox"/> Frequent urinary tract infections <input type="checkbox"/> Urinary or fecal incontinence (<i>leaking urine or stool</i>)			
2	Please provide additional details for all marked disorders in question 1 (<i>for example: date diagnosed, treatment, medications, and treatment center</i>).							
3	Had any of the following surgeries or injuries? (<i>check all that apply</i>)	<input type="checkbox"/> Breast surgery or breast biopsy <input type="checkbox"/> Hysterectomy (<i>uterus removed</i>) Other uterine surgery (<i>C-section, dilation and curettage (D&C), endometrial ablation, removal of fibroids, or other uterine surgery</i>) <input type="checkbox"/> Oophorectomy (<i>ovaries removed</i>) <input type="checkbox"/> One ovary <input type="checkbox"/> Both ovaries			<input type="checkbox"/> Other ovarian surgery <input type="checkbox"/> Removal of ovarian cyst <input type="checkbox"/> Treatment of ovarian torsion (<i>twisting</i>) <input type="checkbox"/> Tubal surgery including tubal ligation <input type="checkbox"/> Surgery for urinary/ fecal incontinence (<i>leaking urine/stool</i>) <input type="checkbox"/> LEEP or cervical cone biopsy <input type="checkbox"/> Vaginal/vulvar surgery or injury			
4	Please provide additional detail for all marked surgeries in question 3 (<i>for example: date diagnosed, treatment center</i>).							
5	Pregnancy. List all pregnancies and associated outcomes and conditions.							
Date (YYYYMMDD)	Vaginal Delivery	C-Section	Miscarriage (<i>loss before 20 weeks</i>)	Stillbirth (<i>loss at or after 20 weeks</i>)	Ectopic (<i>Tubal</i>)	Termination (<i>Abortion</i>)	Complications* (<i>Depression or Anxiety</i>)	Other**
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
List dates, outcomes, treatment location, and complications, if any. *Complications include, but are not limited to: depression, anxiety, high blood pressure in pregnancy, preeclampsia, etc. **Provide additional information, as necessary (for example: gestational diabetes).								

CUI (when filled in)

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Have you ever had:

6	A breast cancer screening (<i>mammogram</i>)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure (<i>if no or unsure, skip to question 8</i>)
	If yes, when was your last screening?	(YYYYMM)
7	An abnormal mammogram result?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure (<i>if no or unsure, skip to question 8</i>)
	If yes, when did the abnormal result occur? What was the abnormal result?	(YYYYMM)/Result
	If applicable, when did you receive treatment or follow-up care? What was the treatment or follow-up care?	(YYYYMM)/Treatment or Follow-up Care
8	A cervical cancer screening (<i>Pap and/or HPV test</i>):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure (<i>if no or unsure, skip to question 10</i>)
	If yes, when was your last screening?	(YYYYMM)
9	An abnormal result showing cancer or pre-cancer or a positive HPV test?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure (<i>if no or unsure, skip to question 10</i>)
	If yes, when did the abnormal result occur? What was the abnormal result?	(YYYYMM)/Result
	If applicable, when did you receive treatment or follow-up care? What was the treatment or follow-up care?	(YYYYMM)/Treatment or Follow-up Care

Are you currently:

10	Are you still having menses (periods)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
	If yes, what was the date of your last menstrual period?	(YYYYMMDD) (<i>skip to question 11</i>)
	If no or unsure, why are you not having menses (<i>periods</i>)?	<input type="checkbox"/> Postmenopausal (<i>no periods for 12 months or more</i>) <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Hormonal suppression (<i>pills/ring/patch/shot/ IUD</i>) <input type="checkbox"/> Pregnant <input type="checkbox"/> Lactating (<i>breastfeeding</i>) <input type="checkbox"/> Other _____
	If you remember, what was the date of your last menstrual period?	(YYYYMM)
11	Experiencing any of the following? (<i>check all that apply</i>)	<input type="checkbox"/> Pelvic pain <input type="checkbox"/> Current or recent genital lesions (<i>sores on or near your vaginal area</i>) <input type="checkbox"/> Pelvic inflammatory disease, uterus prolapse, or displacement <input type="checkbox"/> Pain during intercourse <input type="checkbox"/> Leakage of urine affecting work/ social activities
		<input type="checkbox"/> Leakage of stool <input type="checkbox"/> Low libido (<i>reduced interest in sex</i>) <input type="checkbox"/> Bleeding after menopause <input type="checkbox"/> No If yes, explain:

10. MENTAL HEALTH SCREENING QUESTIONNAIRES

NOTE TO THE SERVICE MEMBER: Please respond to the following screening questionnaires. Your responses will be reviewed by the Examining Clinician, and additional questions may be asked.

10.1. POST-TRAUMATIC STRESS DISORDER (PTSD) SCREEN

#	Question	Response
Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. In the past month, have you...		
1	Had nightmares about the event(s) or thought about the event(s) when you did not want to?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3	Been constantly on guard, watchful, or easily startled?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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4	Felt numb or detached from people, activities, or your surroundings?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?	<input type="checkbox"/> Yes <input type="checkbox"/> No

10.2 DEPRESSION SCREEN

#	Question	Response
Over the last 2 weeks, how often have you been bothered by any of the following problems?		
1	Little interest or pleasure in doing things?	<input type="checkbox"/> Not At All <input type="checkbox"/> Several Days <input type="checkbox"/> More Than Half the Days <input type="checkbox"/> Nearly Every Day
2	Feeling down, depressed, or hopeless?	<input type="checkbox"/> Not At All <input type="checkbox"/> Several Days <input type="checkbox"/> More Than Half the Days <input type="checkbox"/> Nearly Every Day

10.3. ALCOHOL USE SCREEN

#	Question	Response
1	How often did you have a drink containing alcohol in the past year?	<input type="checkbox"/> Never <input type="checkbox"/> Monthly or less <input type="checkbox"/> 2-4 times a month <input type="checkbox"/> 2-3 times per week <input type="checkbox"/> 4 or more times a week
2	How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?	<input type="checkbox"/> 1 or 2 <input type="checkbox"/> 3 or 4 <input type="checkbox"/> 5 or 6 <input type="checkbox"/> 7 to 9 <input type="checkbox"/> 10 or more
3	For men: How often did you have six or more drinks on one occasion in the past year?	<input type="checkbox"/> Never <input type="checkbox"/> Less than monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily, or almost daily
4	For women: How often did you have four or more drinks on one occasion in the past year?	<input type="checkbox"/> Never <input type="checkbox"/> Less than monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Daily, or almost daily

Before submitting, please review your responses to ensure they are accurate and complete.

Signature of Service member	Date of signature (YYYYMMDD)
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Comments/Additional Remarks:

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Comments/Additional Remarks: