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									
NOT	OTE TO THE SERVICE MEMBER: Please complete the following subsections.									
IDEN	DENTIFIER									
#	Question	Response								
1	Name									
2	SSN (Social Security Number)									
3	DoD ID Number									
4	Today's Date (self-assessment date)	(YYYYMMDD)								
1. C	ONTACT 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	Mail Work Phone Personal Phone Government Email Personal Email								
2. PE	ERSONAL INFORMATION									
#	Question	Response								
1	Date of Birth (DoB)	(YYYYMMDD)								
2	Age									
3	Ethnicity	Hispanic/Latino Not Hispanic/Latino								
		American Indian or Alaskan Native Native Hawaiian or Other Pacific Islander								
4	Race (mark all that apply)	AsianUnknown								
"	Trace (main all triat apply)	Black or African American Choose not to answer								
		White								

NAM	E	DOD ID NUMBER	
5	Birth Gender (biological sex)	Female Male Non-binary	
		Female Trans	sgender female <i>(Male to Female)</i>
6	Gender Identity	Male Other	:
U	Gender Identity	Non-binary Choo	se not to answer
		Transgender male <i>(Female to Male)</i>	
7	Administrative Gender (gender identified on official military records)	Female Male	
3. O	CCUPATIONAL INFORMATION		
#	Question	Response	
		Army	e Force
		Navy Coas	t Guard
1	Service	Marine Corps Other	:
		Air Force	
2	Component	Active Duty Reserve National Gua	ard
	·		e Duty – AGR
3	Duty Status		n active duty
4	Usual Occupation (most recent day-to-day job)		
5	What is your military occupational code (for example: MOS, AOC, AFSC, NEC, or Designator Code)?		
4. EX	CAMINATION INFORMATION		
#	Question	Response	
_	5 D 1 ((1)	YYYMMDD)	
1	Exam Date (if known)		
		Separation from period of active service Retire	ement
2	Purpose of Exam	Separation from military service Other	:
		Medical Board	
	Provide date or anticipated date of release from Active	YYYMMDD)	
3	Duty		
	Do you intend to file a claim, or have you already filed a		
4	claim, for disability compensation with the Veterans	Yes No (if no, skip to question 6)	
	Benefits Administration?		
		Fully Developed Claim (FDC) Program	
		IDES (Integrated Disability Evaluation System) (select referred to IDES by your Military Service)	t this option only if you have been
5	 Select the type of claim program/process	BDD (Benefits Delivery at Discharge) (select this option	on only if you meet the criteria for the
Ŭ	program/process	BDD program)	, , , , , , , , , , , , , , , , , , , ,
		Standard Claim Process	
		Not sure	
6	Have you ever filed a disability claim with the VA?	Yes No	
	Have you had a physical exam within 12 months before your separation date?	Yes No Unsure (if no or unsure, skip to S	ection II)
		YYYMM)	
	Date of exam		
7	Tune of every (for everynles, School Elight, Special Duty)		
	Type of exam (for example: School, Flight, Special Duty)		
	Would you like that exam reviewed to determine if it is		
	sufficient to meet the separation health assessment requirements?	Yes No	
	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '		

Separation Health Assessment (SHA) Disability Benefits
Questionnaire - Part A Service Member Identification and SelfAssessment

Please complete all information in the following medical history questionnaire before your appointment for a Assessment. Your responses will help us understand your current health status and wellness. For each rea as indicated and applicable. If you are submitting a VA claim, then an appropriate evaluation, to include exa Benefits Questionnaires (DBQs), will be completed at a later date in order to ensure that the available inform Note: "Qualifying military service" includes: active duty; on orders 30 days or more in support of contingent 180 days or more. This includes active duty, any period of active duty for training, and any period of inactive 1. GENERAL MEDICAL REVIEW # Question List your current medications, including supplements. Date of your most recent military service medical assessment/physical exam	Separation Health Assessment (SHA) Clinical sponse, briefly describe the history, including dates, aminations and completion of any necessary Disability nation is sufficient for rating purposes.				
as indicated and applicable. If you are submitting a VA claim, then an appropriate evaluation, to include exa Benefits Questionnaires (DBQs), will be completed at a later date in order to ensure that the available inform Note: "Qualifying military service" includes: active duty; on orders 30 days or more in support of contingent 180 days or more. This includes active duty, any period of active duty for training, and any period of inactive 1. GENERAL MEDICAL REVIEW # Question List your current medications, including supplements. Date of your most recent military service medical assessment/physical exam	aminations and completion of any necessary Disability nation is sufficient for rating purposes. by operation(s); on continuous active duty orders for e duty. Response				
# Question 1 List your current medications, including supplements. Date of your most recent military service medical assessment/physical exam (YYYYMMDD)	Worse				
List your current medications, including supplements. Date of your most recent military service medical assessment/physical exam (YYYYMMDD)	Worse				
Date of your most recent military service medical assessment/physical exam					
assessment/physical exam					
Compared to your last military service medical assessment/physical exam, your overall health is: The Same Better If better or worse, explain:	Worse				
Overall, how would you rate your health during the PAST MONTH? The Same Better If better or worse, explain:					
Yes No					
During the PAST MONTH, did you have physical health problems (illness or injury) that made it difficult for you to do your work or other regular daily activities? If yes, explain:					
Do you currently require hearing aids, special medical					
supplies, Continuous Positive Airway Pressure (CPAP), adaptive equipment, assistive technology devices, and/or other special accommodations?					
Have you had any surgery since your last health	Yes No				
6 assessment/exam? (Include privately paid elective surgeries.) If yes, explain:					
Since your last health assessment/exam, has a health care					
provider recommended surgery(s) that you have not had (whether you are planning to have it or not)?					
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 (for example: photorefractive keratectomy (PRK), wisdom teeth removal, vasectomy, botox). If yes, explain:					
Have you suffered from any injury or illness while on active					
duty for which you did not seek medical care (to include mental health)? If yes, explain:					
During qualifying military service, have you ever experienced:					
Allergies, including environmental and occupational					
allergies, and adverse reaction to serum, food, insect stings, or medicine. If yes, explain:					
☐Yes ☐No					
High or bad cholesterol If yes, explain:					

NAM	F		DOD ID NUMBER				
	-		DOD ID NOMBER				
		Yes	No				
12	Tuberculosis	If yes, explain:					
12	Tuberculosis						
			No				
13	Coughing up blood	If yes, explair	1:				
		Yes If yes, explair	No v				
14	Asthma	ii yes, explaii					
		Yes	No				
		If yes, explair					
15	Bronchitis						
		Yes	No				
16	Chronic cough or cough at night	If yes, explair	1:				
	ornoring godgir or godgir at riight						
		Yes If yes, explair	No S.				
17	Wheezing, shortness of breath, or difficulty breathing (other than asthma)	ii yes, expiaii	i.				
	(,						
		Yes	No				
	Other lung problems (for example: Chronic Obstructive	If yes, explain:					
18	Pulmonary Disease (COPD), chronic bronchitis, pneumonia, emphysema)						
		Yes	No				
19	Sinusitis	If yes, explain:					
		Yes	No				
		If yes, explair					
20	Thyroid trouble or goiter						
			No				
21	Ear, nose, or throat trouble	If yes, explair	1:				
21	Lai, nose, or unoat nouble						
		Yes If yes, explair	No .				
22	Frequent indigestion or heartburn (reflux)	ii yes, expiair	ı.				
		Yes	No				
		If yes, explair					
23	Stomach or intestinal problems (for example: ulcer)						

NΔM	AME		DOD ID NUMBER				
	- 		Jos is nomber				
		Yes	No				
		If yes, explain:					
24	Kidney problems (for example: stones, infection)						
		Yes	No				
0.5	Liver problems (for example: hepatitis, cirrhosis)	If yes, explai	n:				
25							
			No				
26	Constipation, loose bowels, or diarrhea	If yes, explai	n:				
			No				
27	Gallbladder trouble or gallstones	If yes, explai	n:				
	-						
			1				
		Yes If yes, explai]No				
28	Hernia	ii yes, expiai					
		Yes	No				
		If yes, explai					
29	Rectal disease, hemorrhoids, or blood from rectum						
		Yes	No				
		If yes, explain:					
30	Frequent or painful urination or blood in urine						
		Yes If yes, explai]No				
24	High or law blood gugar	If yes, explai	n:				
31	High or low blood sugar						
			No				
32	Sugar or protein in urine	If yes, explai	n:				
-	3 F						
]No				
33	Diabetes	If yes, explai	n:				
		Dv	lN.				
		Yes If yes, explai]No n·				
34	Recent unexplained gain or loss of weight	ii yos, expiai					
	-						
		Yes	No				
		If yes, explai	4				
35	A head injury, memory loss, or amnesia), oxpidi					

NAM	E		DOD ID NUMBER			
		Yes I	No			
36	Recurring headaches/ migraines; frequent or severe headaches	If yes, explain	:			
	neadaones					
		Yes I	No			
37	Periods of dizziness, fainting, or loss of consciousness	If yes, explain	:			
	r cot madmatic circoc Bicordor (r rob), worry, or circi	Yes I	No			
38		If yes, explain	:			
	mental health diagnosis)					
		Yes I	No			
39	Neurological problems (for example: stroke, seizures, convulsions, epilepsy, fits, tremor)	If yes, explain	:			
	centulations, opinopoy, me, a emoly					
		Yes I	No			
40	Paralysis	If yes, explain	:			
	Meningitis, encephalitis, or other neurological infection or disorder	Yes I	No			
41		If yes, explain	•			
		Yes I	No			
42	Rheumatic fever	If yes, explain:				
		Yes I	No			
43	Prolonged bleeding	If yes, explain:				
		Yes I	No			
44	Blood problems (for example: hemophilia, sickle cell disease)	If yes, explain:				
			No			
45	Immune system problems (for example: HIV, chemotherapy, radiation)	If yes, explain	•			
			No			
46	Angina, also called angina pectoris	If yes, explain:				
			No			
47	Congestive Heart Failure	If yes, explain	:			
			No			
48	Pain, pressure, or discomfort in your chest	If yes, explain:				

NAM			DOD ID NUMBER
	_		
		Yes	No
49	Palpitations, pounding heart, or abnormal heartbeat	If yes, explain	:
		Yes	No
50	Heart murmur or valve problem (for example: mitral valve prolapse)	If yes, explair	:
		Yes	No
51	Coronary heart disease	If yes, explair	:
		Yes	No
52	Heart attack (also called myocardial infarction)	If yes, explain	i.
		Yes	No
53	High blood pressure	If yes, explain	i.
			No
54	Low blood pressure	If yes, explair	
		Yes	No
55	Skin diseases (other than cancer)	If yes, explain	
		Yes	No
56	Cancer (other than skin)	If yes, explain	:
		Yes	No
57	Skin cancer	If yes, explain	:
2. JC	DINT, SPINE, & MUSCULO-SKELETAL SYSTEM		
#	Question		Response
Durin	ng qualifying military service, have you ever experienced pain	and/or injury ir	the following:
			No
1	Head and Neck	If yes, explair	:
		Yes	No
2	Back and Chest	If yes, explain	:
		Yes	No
3	Shoulder/Arm	If yes, explain	:

NAM	E		DOD ID NUMBER			
IVAIVI	_		BOD ID NOMBER			
		Yes]No			
4	Elbow/Forearm	If yes, expla	n:			
		Yes	No			
5	Wrist/Hand/Fingers	If yes, expla	n:			
	-					
		Yes	No			
6	Hip/Thigh	If yes, expla	n:			
		Yes	No			
7	Leg/Knee	If yes, expla	n:			
		Yes	No			
8	Ankle/Foot/Toes	If yes, expla	n:			
3. HE	ALTH & WELLNESS					
#	Question		Response			
	Do you currently use tobacco products (cigarettes, cigars, pipes, etc.), electronic nicotine products (e-cigarette/JUUL, e-hookah, vape-pen, vaporizer, tank system, other similar nicotine products), smokeless tobacco products (chewing tobacco, snuff, dip, snus (pronounced as "snoose"), or dissolvable tobacco)?	Yes	No			
1		If yes, expla	n:			
	Have you smoked at least 100 cigarettes in your entire life? (Note: A pack typically contains 20 cigarettes)	Yes	No			
2		If no, skip to				
		Yes]No			
3	During the past 12 months, have you ever tried to stop	If yes, expla	n:			
	smoking?					
		Yes	No			
4	Have you ever had a serious health problem that was	If yes, expla	n:			
	caused or made worse by smoking?					
	During the past 12 months, how often were you exposed to	Daily				
	secondhand smoke indoors (home, work, vehicle, etc.), a mixture of smoke that comes from the burning end of a					
5	tobacco product (cigarettes, cigars, pipes, etc.), or vapor indoors from a person using an e-cigarette/JUUL, e-	Less than	n daily			
	hookah, vape-pen, vaporizer, tank system, or other similar nicotine product?	Not at all	Not at all			
	medine product:	Yes	No			
6	Do you have any concerns with past use of recreational	If yes, expla				
	drugs or misuse of prescription drugs?					
4. HE	ARING					
#	Question		Response			
	During qualifying military consider have you ever had and	Yes	No			
1	During qualifying military service have you ever had, or do you now have, persistent or recurring noises in your head	If yes, expla	n:			
	or ears? (for example: ringing, buzzing, humming)					

Separation Health Assessment (SHA) Disability Benefits Questionnaire - Part A Service Member Identification and Self-Assessment

NAM	E		DOD ID NUMBER				
		Yes	No				
2	During qualifying military service have you ever had, or do you now have, a change in your hearing that impacts duty performance?	If yes, expla					
		Yes	No				
3	Do you currently, or have you ever worn, a hearing aid?	If yes, expla	in:				
_							
		Yes]No				
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?	If yes, how r experiencing	nany times? For how long? Describe exposure and any symptoms you are still				
5. VI	SION						
#	Question		Response				
		Yes]No				
1	Do you wear corrective lenses (glasses or contacts)?	If yes, expla	in:				
·	be year wear corrective femoles (gladece or correction).						
During qualifying military service, have you ever experienced:							
		Yes	No				
2	Eye disorder or trouble	If yes, expla	in:				
		Yes	No				
,	Surgary to correct vision	If yes, explain:					
3	Surgery to correct vision						
		Yes _	No				
4	Loss of vision in either eye	If yes, explain:					
		Yes	No				
5	Double vision <i>(diplopia)</i>	If yes, expla	in:				
	(P · P · Z						
		Yes	No				
		If yes, expla					
6	Change in your vision that impacts your duty performance	, , ,					
6. HE	AD INJURY						
#	Question		Response				
Durin	g qualifying military service:	1					
		Yes	No Not Applicable				
	As a result of any injury or event, did you receive a jolt or	If yes, check all that apply:					
1	blow to your head that IMMEDIATELY resulted in:		onsciousness ("knocked out")?				
		Losing memory of events before or after the injury?					
	Harry was a state of the same	Seeing s	tars, becoming disoriented, functioning differently, or nearly blacking out?				
2	How many total times did you receive a jolt or blow to your head?						

NAM			DOD ID NUMBER					
INAIVI	E		DOD ID NOMBER					
		Yes	No					
3	Have you ever experienced a head injury, concussion, or Traumatic Brain Injury <i>(TBI)</i> ?	If yes, expla	in:					
	As a result of any injury or event, where you received a jolt or blow to your head, or were diagnosed with a TBI:							
		Yes	No					
4	Have you had prolonged symptoms that have not resolved?	If yes, expla	in:					
		Yes No						
	Are you currently experiencing any prolonged symptoms that have not resolved?	If yes, explain:						
7. EN	IVIRONMENTAL/OCCUPATIONAL							
while explo vacci	deployed, in training, or during other assignments. Consider sions, fuels/fumes, pesticides/insecticides, cleaning agents, s	your potentia olvents, hea oquine) pills)	tal exposures during qualifying military service. Exposures may have occurred lexposure to: burn pits, oil well fires, burning trash, dust storms, air pollution, by metals/depleted uranium, nerve agents/gases, protective medication and persistent chemicals such as PCBs, asbestos, radiation, unusual food/drinking ample: swimming, showering, etc.).					
#	Question		Response					
	Were you potentially exposed to any occupational/	Yes	No Unsure					
1	environmental hazards (described above) while in a qualifying military duty service?	If yes or uns	ure, provide details here:					
		Yes	No Unsure					
2	Have you been based or stationed at a location where an open burn pit was used?	If yes or uns	ure, provide details here:					
		Yes	No Unsure					
3	Have you been potentially exposed to toxic airborne chemicals or other airborne contaminants?	If yes or uns	ure, provide details here:					
4	If 2 or 3 is "Yes" or "Unsure," have you enrolled in the Airborne Hazards and Open Burn Pit Registry?	Yes	No 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:	I wish to:	enroll opt out Not Applicable					
	(See below for more information on the registry.)							
		Yes [No Unsure					
6	While deployed, were you potentially exposed to other deployment-related hazards?	If yes or uns	ure, provide details here:					
7	During any part of your qualifying military service, were you exposed to any of the following? (check all that apply)	A vaccir Firefight Solvents other co Fuels Contam Radiatio	ions to prevent malaria/ malaria prophylaxis, including Mefloquine ne with a possible complication ing foam s or other chemicals that may have caused skin reactions, breathing problems, or ncerns inated water in (include any possible exposure to depleted uranium) exposures of possible concern not listed here led shrapnel					

NAM			DOD ID NUMBER			
10, 111	_					
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 detai	Is of exposure concerns here:			
		Yes	No			
9	Are you currently participating in any specialty occupational exposure examinations?	If yes, explain	n:			
Durin	g qualifying military service, have you ever experienced:					
		Yes	No			
10	A blast or explosion?	If yes, explair	n:			
		Yes	No			
11	A vehicular accident/crash (any vehicle including aircraft)?	If yes, explain	n:			
		Yes	No			
12	A fragment wound or bullet wound?	If yes, explain	n:			
and to de to	he United Arab Emirates; and waters of the Persian Gulf, Arai termine your eligibility. You can join the AHOBPR even if: You do not think you were exposed to specific airborne hazar You are not experiencing symptoms or illnesses you think are You have not filed a VA claim for compensation benefits or all You are still an active duty Service member, reservist, or have www.publichealth.VA.gov/airbornehazards to learn more about are not eligible for the AHOBPR but are concerned about yo	bian Sea, Red rds. e related to ex oplied for VA I e returned to a ut airborne haz	nealth care. active service.			
8. DE	NTAL					
#	Question		Response			
		Yes	No			
1	Do you currently have any dental problems that need to be evaluated?	If yes, explain	n:			
		Yes	No			
2	Have you ever been diagnosed or treated for oral cancer?	If yes, explain	n:			
Durin	g qualifying military service, have you ever experienced:					
		Yes	No			
3	A dental examination where you were told you had a Temporomandibular Disorder <i>(TMD)</i> or Temporomandibular Joint <i>(TMJ)</i> problem?	If yes, explain	n:			
		Yes	No			
4	Your jaw locked open and you could not close the jaw?	If yes, explain:				
	loss of a portion of the borne in transfer and the borne in the borne in transfer and the borne	Yes	No			
5	Loss of a portion of the bone in your upper or lower jaw due to trauma or disease such as osteomyelitis or necrosis?	If yes, explain	n:			

						1555.5					
NAN	IE					DOD ID	NUMBER				
					Yes	No					
6	Loss of any	teeth because of	service-related tra	auma?	If yes, explain:						
7	Physical (a tongue?	<i>natomical)</i> loss or	injury to your mou	th, lips, or	Yes If yes, ex	Yes No f yes, explain:					
9. W	OMEN'S HE	ALTH / FEMALE	REPRODUCTIVE	ORGANS	Not A	pplicable					
#		Que	stion					Respoi	nse		
Durir	ng qualifying	military service, h	ave you ever:								
1	Been diagnosed with and/or treated for any of the following disorders? (check all that apply)			Endo Date Diag IN Recto		D): aroscopy?	[] [] [] [] [] [] [] []	Recurrent miscarriage (2 or more pregnancy losses) Ovarian cancer Cervical cancer Uterine/endometrial cancer Breast cancer Bone loss or osteoporosis Frequent urinary tract infections Urinary or fecal incontinence (leaking urine or stool)			
2	question 1		ails for all marked e diagnosed, treatn enter).								
3	Had any of the following surgeries or injuries? (check all that apply)			Breast surgery or breast biopsy							
Please provide additional detail for all marked surgeries in question 3 (for example: date diagnosed, treatment center).				nent center).							
5	Pregnancy	. List all pregnanci	es and associated	outcomes ar	nd conditio	ns.					
(Y)	Date YYYMMDD)	Vaginal Delivery	C-Section	Miscarriage (before 20 we		oirth (loss at or er 20 weeks)	Ectopic (Tubal)		ination ortion)	Complications* (Depression or Anxiety)	Other**
*Cor	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).										

NAN	NAME			OD IE	NUMBER				
Have	you ever had:		_						
	A breast cancer screening (mammogram)?	Yes	No	<u> </u>	Unsure (if no o	r uns	sure, skip to ques	stion 8)	
6	If yes, when was your last screening?	(YYYYMM)					,	······································	
	An abnormal mammogram result?	Yes	No	o [Unsure (if no o	r uns	sure, skip to ques	stion 8)	
7	If yes, when did the abnormal result occur? What was the abnormal result?	(YYYYMM)i	/Res	sult					
	If applicable, when did you receive treatment or follow-up care? What was the treatment or follow-up care?	(YYYYMM)	(YYYYMM)/Treatment or Follow-up Care						
	A cervical cancer screening (Pap and/or HPV test):	Yes	No	o [Unsure (if no o	r uns	sure, skip to ques	stion 10)	
8	If yes, when was your last screening?	(YYYYMM)							
	An abnormal result showing cancer or pre-cancer or a positive HPV test?	Yes [No		Unsure (if no o	r uns	sure, skip to ques	stion 10)	
9	If yes, when did the abnormal result occur? What was the abnormal result?	(YYYYMM)i	/Res	sult					
	If applicable, when did you receive treatment or follow-up care? What was the treatment or follow-up care?	(YYYYMM)	/Trea	atmen	t or Follow-up Ca	ire			
Are y	ou currently:	'							
	Are you still having menses (periods)?	Yes	No	o [Unsure				
	If yes, what was the date of your last menstrual period?	(YYYYMME	DD) ((skip t	o question 11)				
10	If no or unsure, why are you not having menses (periods)?	Postmenopausal (no periods for 12 months or more) Hysterectomy Hormonal suppression (pills/ring/patch/shot/ IUD) Pregnant Lactating (breastfeeding) Other					omy		
	If you remember, what was the date of your last menstrual period?	(YYYYMM)							
11	Experiencing any of the following? (check all that apply)	(sores de area) Pelvic ir uterus p	t or r on or nflar prola uring	mmato apse, c interc urine	genital lesions your vaginal ry disease, or displacement ourse affecting work/		Leakage of sto Low libido (red Bleeding after of No yes, explain:	uced interest in	sex)
10. N	IENTAL HEALTH SCREENING QUESTIONNAIRES								
	E TO THE SERVICE MEMBER: Please respond to the followard in the followard	ving screenin	ng qu	uestion	nnaires. Your res	pon	ses will be review	ved by the Exar	nining Clinician,
10.1	POST-TRAUMATIC STRESS DISORDER (PTSD) SCREEN	ı							
#	Question					R	lesponse		
Som	retimes things happen to people that are unusually or especial	ly frightening	g, ho	rrible,	or traumatic. In th			you	
1	Had nightmares about the event(s) or thought about the event(s) when you did not want to?	Yes [No	0		<u> </u>	•		
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)?	Yes [No	0					
3	Been constantly on guard, watchful, or easily startled?	Yes [No	0					

NAN	1E		DOD ID NUMBE	ER	
4	Felt numb or detached from people, activities, or your surroundings?	Yes	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?	Yes	No		
10.2	DEPRESSION SCREEN				
#	Question			Response	
Ove	r the last 2 weeks, how often have you been bothered by any o	of the following	problems?		
1	Little interest or pleasure in doing things?	Not At All	Severa	al Days More Than	Half the Days Nearly Every Day
2	Feeling down, depressed, or hopeless?	Not At All	Severa	al Days More Than	Half the Days Nearly Every Day
10.3	. ALCOHOL USE SCREEN				
#	Question			Response	
1	How often did you have a drink containing alcohol in the past year?	Never		Monthly or less	2-4 times a month
		2-3 times	per week	4 or more times a w	
2	How many drinks containing alcohol did you have on a	1 or 2		3 or 4	5 or 6
	typical day when you were drinking in the past year?	7 to 9		10 or more	
3	For men: How often did you have six or more drinks on one	Never		Less than monthly	Monthly
	occasion in the past year?	Weekly		Daily, or almost dai	у
4	For women: How often did you have four or more drinks on one occasion in the past year?	Never		Less than monthly	Monthly
		Weekly		Daily, or almost dai	у
	ore submitting, please review your responses to ensure the	ey are accura	te and complete		Date of signature (VVVVMMDD)
	ore submitting, please review your responses to ensure the lature of Service member	ey are accura	te and complete		Date of signature (YYYYMMDD)
Sign	ature of Service member	ey are accura	te and complete		Date of signature (YYYYMMDD)
Sign		ey are accura	te and complete		Date of signature (YYYYMMDD)
Sign	ature of Service member	ey are accura	te and complete		Date of signature (YYYYMMDD)
Sign	ature of Service member	ey are accura	te and complete		Date of signature (YYYYMMDD)
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Sign	ature of Service member	ey are accura	te and complete		Date of signature (YYYYMMDD)
Sign	ature of Service member	ey are accura	te and complete		Date of signature (YYYYMMDD)

NAME	DOD ID NUMBER
Comments/Additional Remarks:	

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 MEM	BER IDENTIFICATION AND SELF-ASSESSMENT				
	SECTION I - IDENTIFICATION					
NOT	E TO THE SERVICE MEMBER: Please complete the following	ng subsections.				
IDEN	TIFIER					
#	Question	Response				
1	Name	Jane L Doe				
2	SSN (Social Security Number)	999-99-9999				
3	DoD ID Number	123-45-67				
4	Today's Date (self-assessment date)	(YYYYMMDD) 04/15/2023				
1. CC	ONTACT INFORMATION					
#	Question	Response				
1	Current Address	1234 Sample Street, Fairbanks, AK 56789				
2	Work Telephone Number	999-999-9999				
3	Personal Telephone Number	999-999				
4	Government Email	jdoe@dod.gov				
5	Personal Email	janeldoe@msn.com				
6	Preferred method of contact	Mail Work Phone X Personal Phone Government Email Personal Email				
2. PE	RSONAL INFORMATION					
#	Question	Response				
1	Date of Birth (DoB)	(YYYYMMDD) 19950101				
2	Age	28				
3	Ethnicity	Hispanic/Latino x Not Hispanic/Latino				
		x American Indian or Alaskan Native Native Hawaiian or Other Pacific Islander				
4	Rose (mark all that apply)	AsianUnknown				
4	Race (mark all that apply)	Black or African American Choose not to answer				
		x White				

NAM		DOD ID NUMBER
	Jane L Doe	123-45-67
5	Birth Gender (biological sex)	x Female Male Non-binary
		Transgender female (Male to Female)
_		Male Other:
6	Gender Identity	Non-binary Choose not to answer
		Transgender male (Female to Male)
	Administrative Gender (gender identified on official military	
7	records)	x Female Male
3. 00	CCUPATIONAL INFORMATION	
#	Question	Response
	addesilen	x Army Space Force
		Navy Coast Guard
1	Service	
		Marine Corps Other:
		Air Force
2	Component	x Active Duty Reserve National Guard
3	Duty Status	X Active Component Active Duty – AGR
		Active Duty – non AGR Not on active duty
4	Usual Occupation (most recent day-to-day job)	
	- Could Cocapation (most rosent day to day job)	Dentist
5	What is your military occupational code (for example: MOS,	63H
3	AOC, AFSC, NEC, or Designator Code)?	
4. EX	AMINATION INFORMATION	
#	Question	Response
	5 D 1 (11)	(YYYYMMDD)
1	Exam Date (if known)	20230509
		Separation from period of active service Retirement
2	Purpose of Exam	Separation from military service Other:
		Medical Board
	Provide date or anticipated date of release from Active	(YYYYMMDD)
3	Duty	20230601
	Do you intend to file a claim, or have you already filed a	
4	claim, for disability compensation with the Veterans	x Yes No (if no, skip to question 6)
	Benefits Administration?	
		Fully Developed Claim (FDC) Program
		IDES (Integrated Disability Evaluation System) (select this option only if you have been referred to IDES by your Military Service)
_	Soloot the type of claim program/program	BDD (Benefits Delivery at Discharge) (select this option only if you meet the criteria for the
5	Select the type of claim program/process	BDD program)
		Standard Claim Process
		Not sure
6	Have you ever filed a disability claim with the VA?	Yes x No
	Have you had a physical exam within 12 months before	
	your separation date?	x Yes No Unsure (if no or unsure, skip to Section II)
		(YYYYMM)
	Date of exam	20221004
7	T - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	Duby Limitations
	Type of exam (for example: School, Flight, Special Duty)	Duty Limitations
	 Would you like that exam reviewed to determine if it is	
	sufficient to meet the separation health assessment	Yes x No
	requirements?	

		CUI (when filled in)
NAM		DOD ID NUMBER
	Jane L Doe	123-45-67
	\$1000 0000 A 3 4 40 W CL - 400	I - REPORT OF MEDICAL HISTORY
Asser as ind Bene Note:	ssment. Your responses will help us understand your current dicated and applicable. If you are submitting a VA claim, ther fits Questionnaires (DBQs), will be completed at a later date	estionnaire before your appointment for a Separation Health Assessment (SHA) Clinical thealth status and wellness. For each response, briefly describe the history, including dates, nan appropriate evaluation, to include examinations and completion of any necessary Disability in order to ensure that the available information is sufficient for rating purposes. s 30 days or more in support of contingency operation(s); on continuous active duty orders for duty for training, and any period of inactive duty.
1. GE	ENERAL MEDICAL REVIEW	
#	Question	Response
1	List your current medications, including supplements.	Amitriptyline, meclizine, paroxetine, aspirin, methotrexate, vitamin C, vitamin D, calcium.
	Date of your most recent military service medical assessment/physical exam	(YYYYMMDD) 20221004
2		The Same Better Worse
	Compared to your last military service medical assessment/physical exam, your overall health is:	If better or worse, explain: My migraines have become more frequent (1-2x/week) and my anxiety around vehicles makes it impossible to get in one now.
		The Same Better x Worse
3	Overall, how would you rate your health during the PAST	If better or worse, explain:
	MONTH?	My migraines have become more frequent (1-2x/week) and my anxiety around vehicles makes it impossible to get in one now.
	During the BAST MONTH did you have physical health	x Yes No
4	During the PAST MONTH, did you have physical health problems (illness or injury) that made it difficult for you to do your work or other regular daily activities?	If yes, explain: The humming of the dental tools irritates my tinnitus, I am unable to drive to work, my diplopia sometimes makes it hard to properly see my patient's teeth, I miss conversations due to my hearing loss, and my migraines sometimes force me to stop working.
	Do you currently require hearing aids, special medical	Yes x No
5	supplies, Continuous Positive Airway Pressure (CPAP), adaptive equipment, assistive technology devices, and/or other special accommodations?	If yes, explain:
	Have you had any surgery since your last health	Yes x No
6	assessment/exam? (Include privately paid elective surgeries.)	If yes, explain:
	0: 11 11 11	Yes x No
7	Since your last health assessment/exam, has a health care provider recommended surgery(s) that you have not had (whether you are planning to have it or not)?	If yes, explain:
	Since your last health assessment/exam, have you	Yes x No
8	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 (for example: photorefractive keratectomy (PRK), wisdom teeth removal, vasectomy, botox).	If yes, explain:
		Yes x No
9	Have you suffered from any injury or illness while on active duty for which you did not seek medical care (to include mental health)?	If yes, explain:
Durin	g qualifying military service, have you ever experienced:	,
		Yes x No
10	Allergies, including environmental and occupational allergies, and adverse reaction to serum, food, insect stings, or medicine.	If yes, explain:
		Yes x No
11	High or bad cholesterol	If yes, explain:

NAM	E Jane L Doe		DOD ID NUMBER
	,		123-45-67
		Yes x	
12	Tuberculosis	If yes, explain	n:
12	Tubel culosis		
		Yes x	No
13		If yes, explain	n:
	Coughing up blood		
		Yes x	Νο
		If yes, explain	
14	Asthma	, , , , ,	
		Yes x	
15	Bronchitis	ii yes, expiaii	1.
		Yes x	
16	Chronic cough or cough at night	If yes, explain	Υ.
	Chronic cough or cough at night		
	Wheezing, shortness of breath, or difficulty breathing	Yes x	No
995-72		If yes, explain	II.
17	(other than asthma)		
		Yes x	No
	Other lung problems (for example: Chronic Obstructive	If yes, explain	
18	Pulmonary Disease (COPD), chronic bronchitis,		
	pneumonia, emphysema)		
		Yes x	No
	Sinusitis	If yes, explain	1.
19		ii yoo, oxpiaii	
		Yes x	
20	Thyroid trouble or goiter	If yes, explain	1.
			No
21	Ear, nose, or throat trouble	If yes, explain	n:
21	Lar, nose, or timoat trouble	I have time	itus and bassing less in my left and fallowing a say week an 20220742
		I nave tinn	itus and hearing loss in my left ear following a car wreck on 20220712
		Yes x	No
		If yes, explain	n:
22	Frequent indigestion or heartburn (reflux)		
		x Yes	No
		If yes, explain	
23	Stomach or intestinal problems (for example: ulcer)	100	constipation, bloating, and nausea 3-4 times/week following surgical removal of
		metal share	I from abdomen on 20220712.

NAM			DOD ID NUMBER
	Jane L Doe		123-45-67
		Yes	No
		If yes, expla	
24	Kidney problems (for example: stones, infection)		
		Yes 7	No
		If yes, expla	in:
25	Liver problems (for example: hepatitis, cirrhosis)		
26		x Yes	No
	Constipation, loose bowels, or diarrhea	If yes, expla	in:
20	Consupation, 100se bowers, or diarries	Episodes of	constipation 3-4 times/week following surgical removal of
		metal share	l from abdomen on 20220712.
			No
27	Gallbladder trouble or gallstones	If yes, expla	in:
-'	Calibrature of gallotoffee		
28			No
	Hernia	If yes, expla	n:
			Tu.
		Yes x]No
29	Rectal disease, hemorrhoids, or blood from rectum	iii yes, expla	
		Yes x	No
		If yes, expla	
30	Frequent or painful urination or blood in urine		
		Yes x	No
		If yes, expla	in:
31	High or low blood sugar		
]No
32	Sugar or protein in urine	If yes, expla	in:
02	ougai of protein in diffic		
]No
33	Diabetes	If yes, expla	n.
			7.,
		Yes y	No in:
34	Recent unexplained gain or loss of weight	iii yes, expia	
		x Yes	No
		If yes, expla	-
35	A head injury, memory loss, or amnesia	Moderate T	BI sustained in car wreck on 20220712, causing skull fracture, migraines,
		diplopia, ai	nd dizziness.

NAM		DOD ID NUMBER			
	Jane L Doe	123-45-67			
	Recurring headaches/ migraines; frequent or severe headaches	x Yes No			
36		If yes, explain:			
		Migraines 2-3x/week following moderate TBI			
		x Yes No			
37	Periods of dizziness, fainting, or loss of consciousness	If yes, explain:			
		Episodes of dizziness 2-3x/day following moderate TBI			
	Mental health problems (for example: depression, anxiety,	xYes No			
38	Post-Traumatic Stress Disorder (PTSD), worry, or other	If yes, explain: Diagnosis of PTSD on 09/04/2022 with anxiety, depression, trouble sleeping, intrusive thoughts,			
	mental health diagnosis)	lack of interest in social activities, nightmares, and avoidance.			
		Yes No			
39	Neurological problems (for example: stroke, seizures, convulsions, epilepsy, fits, tremor)	If yes, explain:			
		Yes x No			
40	Paralysis	If yes, explain:			
	Meningitis, encephalitis, or other neurological infection or disorder	Yes xNo			
41		If yes, explain:			
	Rheumatic fever	Yes No			
42		If yes, explain:			
		Yes No			
43	Prolonged bleeding	If yes, explain:			
		Yes x No			
44	Blood problems (for example: hemophilia, sickle cell disease)	If yes, explain:			
		Yes x No			
45	Immune system problems (for example: HIV, chemotherapy, radiation)	If yes, explain:			
		Yes No			
46	Angina, also called angina pectoris	If yes, explain:			
		Yes x No			
47	Congestive Heart Failure	If yes, explain:			
		Yes x No			
48	Pain, pressure, or discomfort in your chest	If yes, explain:			

NAM		DOD ID NUMBER		
	Jane L Doe	123-45-67		
		Yes x No		
49	Palpitations, pounding heart, or abnormal heartbeat	If yes, explain:		
		Yes xNo		
	Heart murmur or valve problem <i>(for example: mitral valve</i>	If yes, explain:		
50	prolapse)	in yes, explain.		
		Yes x No		
51	Coronary heart disease	If yes, explain:		
		Yes No		
52	Heart attack (also called myocardial infarction)	If yes, explain:		
52	Treat attack (also called myocardial linarction)			
		Yes No		
53	High blood pressure	If yes, explain:		
		Yes x No		
54	Low blood pressure	If yes, explain:		
		TVo The		
		Yes No If yes, explain:		
55	Skin diseases (other than cancer)	in yes, oxpanii		
		Yes XNo		
56	Cancer (other than skin)	If yes, explain:		
		Yes x No		
57	Skin cancer	If yes, explain:		
"	SKIT GATIOCI			
	DINT, SPINE, & MUSCULO-SKELETAL SYSTEM	1		
#	Question	Response		
Durin	g qualifying military service, have you ever experienced pain	n and/or injury in the following:		
		x Yes No		
1	Head and Neck	If yes, explain:		
		TBI with skull fracture in car wreck on 20220712.		
		Yes x No		
_	Deals and Object	If yes, explain:		
2	Back and Chest	2 2 2 2 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
		Yes No		
3	Shoulder/Arm	If yes, explain:		

NAM	Jane L Doe		DOD ID NUMBER 123-45-67	
		Yes x	No	
4	Elbow/Forearm	If yes, explair	n:	
		Yes	No	
_	NA : 1/1 1/2	If yes, explain		
5	Wrist/Hand/Fingers		wrist, post-surgical repair on 20220715, with limited motion	
		Yes x		
6	Hip/Thigh	If yes, explair	1.	
			No	
7	Leg/Knee	If yes, explair	n:	
		Yes x	No	
8	Ankle/Foot/Toes	If yes, explair	n:	
3. HE	EALTH & WELLNESS			
#	Question		Response	
	Do you currently use tobacco products (cigarettes, cigars,	Yes x	No	
1	pipes, etc.), electronic nicotine products (e-cigarette/JUUL, e-hookah, vape-pen, vaporizer, tank system, other similar nicotine products), smokeless tobacco products (chewing tobacco, snuff, dip, snus (pronounced as "snoose"), or dissolvable tobacco)?	If yes, explair	1:	
2	Have you smoked at least 100 cigarettes in your entire life? (Note: A pack typically contains 20 cigarettes)		No	
		If no, skip to		
			No	
3	During the past 12 months, have you ever tried to stop smoking?	If yes, explair	1:	
		Yes	No	
4	Have you ever had a serious health problem that was caused or made worse by smoking?	If yes, explair	n:	
	and the same of th			
	During the past 12 months, how often were you exposed to	Daily		
	secondhand smoke indoors (home, work, vehicle, etc.), a mixture of smoke that comes from the burning end of a			
5	tobacco product (cigarettes, cigars, pipes, etc.), or vapor indoors from a person using an e-cigarette/JUUL, e-	Less than	daily	
	hookah, vape-pen, vaporizer, tank system, or other similar	Not at all		
	nicotine product?	Yes x	No	
	Do you have any concerns with past use of recreational	If yes, explain		
6	drugs or misuse of prescription drugs?	, , ., ., .,		
00.00 000000	ARING	Ī	Decreases	
#	Question	Yes	No Response	
4	During qualifying military service have you ever had, or do	If yes, explair		
1	you now have, persistent or recurring noises in your head or ears? (for example: ringing, buzzing, humming)	Diagnosed	with tinnitus on 20221004 after a car explosion. There is a constant,	
		dull buzzing in the left ear.		

NAM	E Jane L Doe		DOD ID NUMBER 123-45-67			
		x Yes	No			
_	During qualifying military service have you ever had, or do	If yes, explair	:			
2	you now have, a change in your hearing that impacts duty performance?	The noise the	dental tools make irritates the tinnitus, making it difficult to properly focus			
		on treating my patients. Hearing loss in the left ear also causes me to miss people talking to me f that direction.				
		Yes x	No			
ر ا	Do you commently on house you are your a housing oid?	If yes, explair	: :			
3	Do you currently, or have you ever worn, a hearing aid?					
		Yes x	No			
			any times? For how long? Describe exposure and any symptoms you are still			
	During your deployment or during military training, were	experiencing.				
4	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?	The hear	ing loss and tinnitus are a direct result of the on-duty car wreck on 20220712			
5. VI	SION					
#	Question		Response			
		Yes x	No			
1	Do you wear corrective lenses (glasses or contacts)?	If yes, explair				
	gradule of control teneds (gradule of contracto).	Diagno	sed with post-chiasmal diplopia on 20220816			
Durin	g qualifying military service, have you ever experienced:					
	Eye disorder or trouble	x Yes	No			
2		If yes, explain				
		□Vee □	No			
3	Surgery to correct vision	If yes, explain:				
		Yes x	No			
١.,	, , , , , , , , , , , , , , , , , , ,	If yes, explain				
4	Loss of vision in either eye	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
		Yes	No			
5	Double vision (diplopia)	If yes, explair	:			
ľ	Bouble vision (arpropra)	Muscle Dysfunction in left eye following TBI causing daily episodes of diplopia.				
			No			
6	Change in your vision that impacts your duty performance	If yes, explair	Ľ			
		Diplopia e	pisodes make it difficult to properly see to treat my patients.			
	AD INJURY	1				
#	Question		Response			
Durin	g qualifying military service:					
			No Not Applicable			
	As a result of any injury or event, did you receive a jetter	If yes, check				
1	As a result of any injury or event, did you receive a jolt or blow to your head that IMMEDIATELY resulted in:	Losing co	nsciousness ("knocked out")?			
	-	Losing memory of events before or after the injury?				
		x Seeing sta	rs, becoming disoriented, functioning differently, or nearly blacking out?			
2	How many total times did you receive a jolt or blow to your head?	One time				

NAM	 E		DOD ID NUMBER				
	Jane L Doe	123-45-67					
		x Yes	No				
3	Have you ever experienced a head injury, concussion, or	If yes, explain:					
3	Traumatic Brain Injury <i>(TBI)</i> ?	I sustai	ined a moderate TBI in a car wreck on 20220712				
		1 Sustai	med a moderate 151 m a car wicek on 20220712				
	As a result of any injury or event, where you received a jolt or blow to your head, or were diagnosed with a TBI:						
	of blow to your flead, or were diagnosed with a fibi.	x Yes	No The state of th				
	Have you had prolonged symptoms that have not	If yes, expla					
	resolved?		experience episodes of diplopia, migraines, and dizziness.				
4		3.50	and the same of th				
		x Yes	No				
	Are you currently experiencing any prolonged symptoms	If yes, expla	in:				
	that have not resolved?	I sti	ll experience episodes of diplopia, migraines, and dizziness.				
7. EN	IVIRONMENTAL/OCCUPATIONAL						
while explo vacci	deployed, in training, or during other assignments. Consider sions, fuels/fumes, pesticides/insecticides, cleaning agents, s	your potentia solvents, heav oquine) pills)	atal exposures during qualifying military service. Exposures may have occurred all exposure to: burn pits, oil well fires, burning trash, dust storms, air pollution, by metals/depleted uranium, nerve agents/gases, protective medication and persistent chemicals such as PCBs, asbestos, radiation, unusual food/drinking ample: swimming, showering, etc.).				
#	Question		Response				
	Mara you natantially avenaged to any appunational/	Yes x	No Unsure				
1	Were you potentially exposed to any occupational/ environmental hazards (described above) while in a	If yes or uns	sure, provide details here:				
	qualifying military duty service?						
		Yes x	No Unsure				
	Have you been based or stationed at a location where an open burn pit was used?		sure, provide details here:				
2		ii yoo o, ame	one, promocodanie nord.				
		Yes	No x Unsure				
3	Have you been potentially exposed to toxic airborne chemicals or other airborne contaminants?	If yes or uns	sure, provide details here:				
		I was expo	osed to smoke from the car fire and explosion until emergency workers pulled me free.				
4	If 2 or 3 is "Yes" or "Unsure," have you enrolled in the Airborne Hazards and Open Burn Pit Registry?	Yes ,	No Not Applicable				
	Federal law requires eligible members to enroll in the						
	Airborne Hazards and Open Burn Pit Registry or to opt-out.						
5	If eligible choose one:	I wish to:	x enroll opt out Not Applicable				
	(See below for more information on the registry.)						
		Yes	No Unsure				
	While deployed, were you potentially exposed to other deployment-related hazards?	If yes or uns	sure, provide details here:				
6							
		Medicat	ions to prevent malaria/ malaria prophylaxis, including Mefloquine				
	During any part of your qualifying military service, were you exposed to any of the following? (check all that apply)		ne with a possible complication				
		Firefighting foam					
		Solvents or other chemicals that may have caused skin reactions, breathing problems, or					
		│					
7		Contaminated water					
		Radiation (include any possible exposure to depleted uranium)					
		Other exposures of possible concern not listed here					
		x Embedded shrapnel					
		Unsure					

		(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
NAM	Jane L Doe		DOD ID NUMBER 123-45-67					
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.		of exposure concerns here: al was embedded in my abdomen and surgically removed after the car wreck.					
9	Are you currently participating in any specialty occupational exposure examinations?	Yes No If yes, explain:						
Durin	g qualifying military service, have you ever experienced:							
10	A blast or explosion?	x Yes No If yes, explain: Explosion after car wreck on 20220712						
11	A vehicular accident/crash (any vehicle including aircraft)?	x Yes No If yes, explain: Car wreck while on duty on 20220712						
12	A fragment wound or bullet wound?	If yes, explain:	netal was embedded in my abdomen and surgically removed after the car wreck.					
Are y opera bodie and to de	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							
8. DE	NTAL							
#	Question		Response					
1	Do you currently have any dental problems that need to be evaluated?	Yes x N If yes, explain:						
2	Have you ever been diagnosed or treated for oral cancer?	Yes XN						
Durin	g qualifying military service, have you ever experienced:							
3	A dental examination where you were told you had a Temporomandibular Disorder <i>(TMD)</i> or Temporomandibular Joint <i>(TMJ)</i> problem?	Yes x N						
4	Your jaw locked open and you could not close the jaw?	Yes x N If yes, explain:						
	Loss of a partian of the bare in view with a large	Yes X	lo					
5	Loss of a portion of the bone in your upper or lower jaw due to trauma or disease such as osteomyelitis or necrosis?	If yes, explain:						

NAM	E		Jane L Doe	DOD ID NUMBER 123-45-67									
					Yes	s x No							
6	Loss of any	teeth because of	service-related tra	uma?	If yes, explain:								
7	Physical (ai tongue?	natomical) loss or	injury to your mout	Yes No If yes, explain:									
9. W	OMEN'S HE	ALTH / FEMALE I	REPRODUCTIVE	ORGANS	Not Applicable								
#		Que	stion		Response								
During qualifying military service, have you ever:													
1	Been diagnosed with and/or treated for any of the following disorders? (check all that apply)				Fibroids (leiomyomas) Endometriosis Date (YYYYMMDD): Diagnosed by laparoscopy? Yes No Unsure Rectocele or cystocele Polycystic Ovarian Syndrome (PCOS) Infertility/difficulty getting pregnant				Recurrent miscarriage (2 or more pregnancy losses) Ovarian cancer Cervical cancer Uterine/endometrial cancer Breast cancer Bone loss or osteoporosis Frequent urinary tract infections Urinary or fecal incontinence (leaking urine or stool)				
2	question 1	vide additional deta (for example: date s, and treatment ce	ails for all marked of diagnosed, treatmenter).										
3	Had any of the following surgeries or injuries? (check all that apply)					Breast surgery or breast biopsy Hysterectomy (uterus removed) Other uterine surgery (C-section, dilation and curettage (D&C), endometrial ablation, removal of fibroids, or other uterine surgery) Oophorectomy (ovaries removed) One ovary Both ovaries Other ovarian surgery Removal of ovarian cyst Treatment of ovarian torsion (twisting) Tubal surgery including tubal ligation Surgery for urinary/ fecal incontinence (leaking urine/stool) LEEP or cervical cone biopsy Vaginal/vulvar surgery or injury							
4	Please provide additional detail for all marked surgeries in question 3 (for example: date diagnosed, treatment center).												
5	Pregnancy.	List all pregnancie	es and associated	outcomes ar	nd cond	itions.							
(YY	Date (YYYYMMDD) Vaginal Delivery C-Section Miscarriage before 20 we					Termination (Abortion)		Complications* (Depression or Anxiety)	Other**				
*Com	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).												

NAM	E Jane L Doe	DOD ID NUMBER 123-45-67						
Have you ever had:								
	A breast cancer screening (mammogram)?	Yes X No Unsure (if no or unsure, skip to question 8)						
6	If yes, when was your last screening?	(YYYYMM)						
	An abnormal mammogram result?	Yes	No Unsure (if no or	unsure, skip to quest	tion 8)			
7	If yes, when did the abnormal result occur? What was the abnormal result?	(YYYYMM)/F	· —					
	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						
	A cervical cancer screening (Pap and/or HPV test):	xYes No Unsure (if no or unsure, skip to question 10)						
8	If yes, when was your last screening?	(YYYYMM)	202203					
	An abnormal result showing cancer or pre-cancer or a positive HPV test?			unsure, skip to quest	tion 10)			
9	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 y	ou currently:							
	Are you still having menses (periods)?	x Yes	No Unsure					
	If yes, what was the date of your last menstrual period?	(YYYYMMDD) (skip to question 11) 20230326						
10	If no or unsure, why are you not having menses (periods)?	Postmenopausal (no periods for 12 months or more) Hysterectomy Hormonal suppression (pills/ring/patch/shot/ IUD) Pregnant Lactating (breastfeeding) Other						
	If you remember, what was the date of your last menstrual period?	(YYYYMM)						
11	Experiencing any of the following? (check all that apply)	(sores or area) Pelvic in	or recent genital lesions or near your vaginal	Leakage of stoo Low libido (redu Bleeding after n No If yes, explain:	uced interest in sex)			
			rolapse, or displacement ing intercourse	ii yes, explain.				
		Leakage social ac	of urine affecting work/ tivities					
10. N	ENTAL 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.	10.1. POST-TRAUMATIC STRESS DISORDER (PTSD) SCREEN							
#	# Question Response							
Some	ometimes 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?	x Yes]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)?	x Yes]No					
3	Been constantly on guard, watchful, or easily startled?	x Yes]No					

Page of 15

NAME Jane L Doe								
le, activities, or your	x Yes	No						
	s for XYes No							
caused? 0.2 DEPRESSION SCREEN								
n				Response				
you been bothered by any o	of the following	problems?						
things?	Not At All	Sev	eral Days	More Than	Half the Days	x Nearly Every Day		
eless?	☐Not At All	Sev	eral Days	More Than	Half the Days	x Nearly Every Day		
n				Response				
ontaining alcohol in the	Never	per week				times a month		
	x 1 or 2				5 c	or 6		
ig in the past year?	7 to 9		10 c	or more				
For men: How often did you have six or more drinks on one occasion in the past year?	Never		Less	s than monthly	Mo	onthly		
	Weekly		Dail	y, or almost dai	ly			
ave four or more drinks on	Never					onthly		
ur recogness to encure th		to and compl		y, or almost dai	ıy			
Before submitting, please review your responses to ensure they are accurate and complete. Signature of Service member Date of signature (YYYYMMDD)								
Jane L Doe 04/15/2023						15/2023		
testine. I continue to have ep cured and I was diagnosed wi ast 3 months. I also experiency by to the TBI on 20220816. I cond I was diagnosed with tinni h. It was surgically repaired on 109/04/2022. My current sy	isodes of consti th a moderate T ce episodes of di experience daily tus and hearing on 20220715. In	pation, nausea, PBI. I began hav izziness 2-3x/d v episodes of di loss on 20221 now have full us	, and bloating migraine lay that some plopia. 004.	g 3-4x/week. es about 3-4x/me etimes make me d, but limited me	onth, and those h stagger when I w	nave increased in valk. Finally, I was		
	eless? on ontaining alcohol in the chol did you have on a ang in the past year? e six or more drinks on one ave four or more drinks on ur responses to ensure the Jane L Doe 1220712, I was in good health attestine. I continue to have ep tured and I was diagnosed wi ast 3 months. I also experience ry to the TBI on 20220816. I cond I was diagnosed with tinni th. It was surgically repaired of	ing yourself or others for event(s) may have X	ing yourself or others for event(s) may have	ing yourself or others for event(s) may have Yes No	ing yourself or others for event(s) may have X Yes	ing yourself or others for event(s) may have		

