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 *(Social Security Number)*	
3	DoD ID Number	
4	Today's Date *(self-assessment date)*	*(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	☐ Mail ☐ Work Phone ☐ Personal Phone ☐ Government Email ☐ Personal Email

2. PERSONAL INFORMATION

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

NAME	DOD ID NUMBER

5	Birth Sex *(biological sex)*	☐ Female ☐ Male

3. OCCUPATIONAL INFORMATION

#	Question	Response
1	Service	☐ Army ☐ Space Force ☐ Navy ☐ Coast Guard ☐ Marine Corps ☐ Other: _____ ☐ Air Force
2	Component	☐ Active Duty ☐ Reserve ☐ National Guard
3	Duty Status	☐ Active Component ☐ Active Duty – AGR ☐ Active Duty – non AGR ☐ Not on 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. EXAMINATION INFORMATION

#	Question	Response
1	Exam Date *(if known)*	*(YYYYMMDD)*
2	Purpose of Exam	☐ Separation from period of active service ☐ Retirement ☐ Separation from military service ☐ Other: _____ ☐ 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?	☐ Yes ☐ No *(if no, skip to question 6)*
5	Select the type of claim program/process	☐ 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)* ☐ BDD (Benefits Delivery at Discharge) *(select this option only if you meet the criteria for the BDD program)* ☐ Standard Claim Process ☐ Not sure
6	Have you ever filed a disability claim with the VA?	☐ Yes ☐ No
7	Have you had a physical exam within 12 months before your separation date?	☐ Yes ☐ No ☐ Unsure *(if no or unsure, skip to Section II)*
	Date of exam	*(YYYYMM)*
	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

NAME	DOD ID NUMBER

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:	☐ The Same ☐ Better ☐ Worse If better or worse, explain:
3	Overall, how would you rate your health during the PAST MONTH?	☐ The Same ☐ Better ☐ Worse If better or worse, explain:
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?	☐ Yes ☐ 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?	☐ Yes ☐ No If yes, explain:
6	Have you had any surgery since your last health assessment/exam? *(Include privately paid elective surgeries.)*	☐ Yes ☐ No If yes, explain:
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)*?	☐ Yes ☐ No If yes, explain:
8	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)*.	☐ Yes ☐ 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 *(to include mental health)*?	☐ Yes ☐ 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.	☐ Yes ☐ No If yes, explain:
11	High or bad cholesterol	☐ Yes ☐ No If yes, explain:

NAME	DOD ID NUMBER

		☐ Yes ☐ No

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

NAME	DOD ID NUMBER

		☐ Yes ☐ No

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

NAME	DOD ID NUMBER

		☐ Yes ☐ No

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

NAME	DOD ID NUMBER

		☐ Yes ☐ No

49	Palpitations, pounding heart, or abnormal heartbeat	If yes, explain:
50	Heart murmur or valve problem *(for example: mitral valve prolapse)*	☐ Yes ☐ No If yes, explain:
51	Coronary heart disease	☐ Yes ☐ No If yes, explain:
52	Heart attack *(also called myocardial infarction)*	☐ Yes ☐ No If yes, explain:
53	High blood pressure	☐ Yes ☐ No If yes, explain:
54	Low blood pressure	☐ Yes ☐ No If yes, explain:
55	Skin diseases *(other than cancer)*	☐ Yes ☐ No If yes, explain:
56	Cancer *(other than skin)*	☐ Yes ☐ No If yes, explain:
57	Skin cancer	☐ Yes ☐ 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	☐ Yes ☐ No If yes, explain:
2	Back and Chest	☐ Yes ☐ No If yes, explain:
3	Shoulder/Arm	☐ Yes ☐ No If yes, explain:

NAME	DOD ID NUMBER

		☐ Yes ☐ No

4	Elbow/Forearm	If yes, explain:
5	Wrist/Hand/Fingers	☐ Yes ☐ No If yes, explain:
6	Hip/Thigh	☐ Yes ☐ No If yes, explain:
7	Leg/Knee	☐ Yes ☐ No If yes, explain:
8	Ankle/Foot/Toes	☐ Yes ☐ No If yes, explain:

3. HEALTH & WELLNESS

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

NAME	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, explain:
3	Do you currently, or have you ever worn, a hearing aid?	☐ Yes ☐ 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?	☐ Yes ☐ 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 (*glasses or contacts)*?	☐ Yes ☐ No If yes, explain:
During qualifying military service, have you ever experienced:		
2	Eye disorder or trouble	☐ Yes ☐ No If yes, explain:
3	Surgery to correct vision	☐ Yes ☐ No If yes, explain:
4	Loss of vision in either eye	☐ Yes ☐ No If yes, explain:
5	Double vision *(diplopia)*	☐ Yes ☐ No If yes, explain:
6	Change in your vision that impacts your duty performance	☐ Yes ☐ 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:	☐ Yes ☐ No ☐ Not Applicable If yes, check all that apply: ☐ Losing consciousness *("knocked out")*? ☐ Losing memory of events before or after the injury? ☐ 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?	

NAME	DOD ID NUMBER

		☐ Yes ☐ No

3	Have you ever experienced a head injury, concussion, or Traumatic Brain Injury *(TBI)*?	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?	☐ Yes ☐ No
		If yes, explain:
	Are you currently experiencing any prolonged symptoms that have not resolved?	☐ Yes ☐ 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?	☐ Yes ☐ No ☐ 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?	☐ Yes ☐ No ☐ Unsure
		If yes or unsure, provide details here:
3	Have you been potentially exposed to toxic airborne chemicals or other airborne contaminants?	☐ Yes ☐ No ☐ 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?	☐ 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: *(See below for more information on the registry.)*	I wish to: ☐ enroll ☐ opt out ☐ Not Applicable
6	While deployed, were you potentially exposed to other deployment-related hazards?	☐ Yes ☐ No ☐ 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)*	☐ Medications to prevent malaria/ malaria prophylaxis, including Mefloquine ☐ A vaccine with a possible complication ☐ Firefighting foam ☐ Solvents or other chemicals that may have caused skin reactions, breathing problems, or other concerns ☐ Fuels ☐ Contaminated water ☐ Radiation *(include any possible exposure to depleted uranium)* ☐ Other exposures of possible concern not listed here ☐ Embedded shrapnel ☐ 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?	☐ Yes ☐ No If yes, explain:
During qualifying military service, have you ever experienced:		
10	A blast or explosion?	☐ Yes ☐ No If yes, explain:
11	A vehicular accident/crash *(any vehicle including aircraft)*?	☐ Yes ☐ No If yes, explain:
12	A fragment wound or bullet wound?	☐ Yes ☐ 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?	☐ Yes ☐ No If yes, explain:
2	Have you ever been diagnosed or treated for oral cancer?	☐ Yes ☐ 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?	☐ Yes ☐ No If yes, explain:
4	Your jaw locked open and you could not close the jaw?	☐ Yes ☐ 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?	☐ Yes ☐ No If yes, explain:

NAME	DOD ID NUMBER

6	Loss of any teeth because of service-related trauma?	☐ Yes ☐ No If yes, explain:
7	Physical *(anatomical)* loss or injury to your mouth, lips, or tongue?	☐ Yes ☐ No If yes, explain:

9. WOMEN'S HEALTH / FEMALE REPRODUCTIVE ORGANS ☐ Not Applicable

#	Question	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	Please provide additional details for all marked disorders in question 1 *(for example: date diagnosed, treatment, medications, and treatment center)*.	
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 pregnancies and associated outcomes and conditions.	

Date *(YYYYMMDD)*	Vaginal Delivery	C-Section	Miscarriage *(loss before 20 weeks)*	Stillbirth *(loss at or after 20 weeks)*	Ectopic *(Tubal)*	Termination *(Abortion)*	Complications* *(Depression or Anxiety)*	Other**
	☐	☐	☐	☐	☐	☐	☐	☐

Add Row **Remove Row**

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).*

NAME	DOD ID NUMBER

Have you ever had:		
6	A breast cancer screening *(mammogram)*?	☐ Yes ☐ No ☐ Unsure *(if no or unsure, skip to question 8)*
	If yes, when was your last screening?	*(YYYYMM)*
7	An abnormal mammogram result?	☐ Yes ☐ No ☐ Unsure *(if no or unsure, skip to question 8)*
	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 *(Pap and/or HPV test)*:	☐ Yes ☐ No ☐ Unsure *(if no or unsure, skip to question 10)*
	If yes, when was your last screening?	*(YYYYMM)*
9	An abnormal result showing cancer or pre-cancer or a positive HPV test?	☐ Yes ☐ No ☐ Unsure *(if no or unsure, skip to question 10)*
	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)?	☐ Yes ☐ No ☐ Unsure
	If yes, what was the date of your last menstrual period?	*(YYYYMMDD) (skip to question 11)*
	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)*	☐ Pelvic pain ☐ Current or recent genital lesions *(sores on or near your vaginal area)* ☐ Pelvic inflammatory disease, uterus prolapse, or displacement ☐ Pain during intercourse ☐ Leakage of urine affecting work/ social activities ☐ Leakage of stool ☐ Low libido *(reduced interest in sex)* ☐ Bleeding after menopause ☐ 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?	☐ 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)?	☐ Yes ☐ No
3	Been constantly on guard, watchful, or easily startled?	☐ Yes ☐ No

NAME	DOD ID NUMBER

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
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?	☐ Not At All ☐ Several Days ☐ More Than Half the Days ☐ Nearly Every Day
2	Feeling down, depressed, or hopeless?	☐ Not At All ☐ Several 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 week
2	How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?	☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more
3	For men: How often did you have six or more drinks on one occasion in the past year?	☐ Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily, or almost daily
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 daily

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

Signature of Service member	Date of signature *(YYYYMMDD)*