33823

PRE-DEPLOYMENT Health Assessment

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

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

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

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

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

Demographics

Last Name

First Name **MI**

Deploying Unit

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

Social Security Number - -

DOB (dd/mm/yyyy) / /

Gender

- O Male
- O Female

Service Branch

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

Component

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

Pay Grade

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

Location of Operation

- O Europe
- O SW Asia
- O SE Asia
- O Asia (Other)
- O South America
- O Australia
- O Africa
- O Central America
- O Unknown

Deployment Location (IF KNOWN) (CITY, TOWN, or BASE):

List country (IF KNOWN):

Name of Operation:

Administrator Use Only

Indicate the status of each of the following:

Yes	No	N/A	
O	O	O	Medical threat briefing completed
O	O	O	Medical information sheet distributed
O	O	O	Serum for HIV drawn within 12 months
O	O	O	Immunizations current
O	O	O	PPD screening within 24 months

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PLEASE FILL IN SOCIAL SECURITY # ___ - ___ - ____

Health Assessment

1. Would you say your health in general is: O Excellent O Very Good O Good O Fair O Poor
2. Do you have any medical or dental problems? O Yes O No
3. Are you currently on a profile, or light duty, or are you undergoing a medical board? O Yes O No
4. Are you pregnant? (FEMALES ONLY) O Don't Know O Yes O No
5. Do you have a 90-day supply of your prescription medication or birth control pills? O N/A O Yes O No
6. Do you have two pairs of prescription glasses (if worn) and any other personal medical equipment? O N/A O Yes O No
7. During the past year, have you sought counseling or care for your mental health? O Yes O No
8. Do you currently have any questions or concerns about your health? O Yes O No

Please list your concerns: _____

_____

Service Member Signature

I certify that responses on this form are true.

Pre-Deployment Health Provider Review (For Health Provider Use Only)

After interview/exam of patient, the following problems were noted and categorized by Review of Systems. More than one may be noted for patients with multiple problems. Further documentation of problem to be placed in medical records.

REFERRAL INDICATED

- O None
- O Cardiac
- O Combat / Operational Stress Reaction
- O Dental
- O Dermatologic
- O ENT
- O Eye
- O Family Problems
- O Fatigue, Malaise, Multisystem complaint
- O GI
- O GU
- O GYN
- O Mental Health
- O Neurologic
- O Orthopedic
- O Pregnancy
- O Pulmonary
- O Other _____

FINAL MEDICAL DISPOSITION:

O **Deployable** O **Not Deployable**

Comments: (If not deployable, explain)

_____

_____

_____

I certify that this review process has been completed.

Provider's signature and stamp:

Date (dd/mm/yyyy) __ __ / __ __ / __ __ __ __

End of Health Review

Reset

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