This form must be completed electronically. Handwritten forms will not be accepted.

POST-DEPLOYMENT HEALTH ASSESSMENT (PDHA)

PRIVACY ACT STATEMENT

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

PRINCIPAL PURPOSE(S): To assess your state of health after deployment in support of military operations and to assist military healthcare providers in identifying and providing present and future medical care you may need. The information you provide may result in a referral for additional healthcare that may include medical, dental or behavioral healthcare or diverse community support services.

ROUTINE USE(S): In addition to those disclosures generally permitted under 5 U.S.C. 552a(b) of the Privacy Act, to other Federal and State agencies and civilian healthcare providers, as necessary, in order to provide necessary medical care and treatment. Responses may be used to guide possible referrals.

DISCLOSURE: Voluntary. If not provided, healthcare WILL BE furnished, but comprehensive care may not be possible.

INSTRUCTIONS: Please read each question completely and carefully before entering your response or marking your selection. **YOU ARE ENCOURAGED TO ANSWER EACH QUESTION. ANSWERING THESE QUESTIONS WILL NOT DELAY YOUR RETURN HOME.** Withholding or providing inaccurate information may impair a healthcare provider's ability to identify health problems and refer you to appropriate sources for additional evaluation or treatment. If you do not understand a question, please ask for help.

DEMOGRAPHICS

Last Name _____ **First Name** _____ **Middle Initial** _____

Social Security Number _____ **Today's Date** *(dd/mmm/yyyy)* _____

Name of Your Unit during this Deployment _____ **Date of Birth** *(dd/mmm/yyyy)* _____

Gender
- ○ Male
- ○ Female

Service Branch
- ○ Air Force
- ○ Army
- ○ Coast Guard
- ○ Marine Corps
- ○ Navy
- ○ GS Employee
- ○ Other

Component
- ○ Active Duty
- ○ National Guard
- ○ Reserves
- ○ Civilian Government Employee
- ○ Other

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

Date of arrival in theater *(dd/mmm/yyyy)* _____

Date of departure from theater *(dd/mmm/yyyy)* _____ **Name of Operation:** _____

Location of Operation. To what areas were you mainly deployed *(land-based operations for more than 30 days)*?
(Please mark all that apply, including the number of months spent at each location.)

- ○ Country 1 _____ Time at location *(months)* _____
- ○ Country 2 _____ Time at location *(months)* _____
- ○ Country 3 _____ Time at location *(months)* _____
- ○ Country 4 _____ Time at location *(months)* _____
- ○ Country 5 _____ Time at location *(months)* _____

Occupational specialty during this deployment *(MOS/AOC, NEC/NOBC, or AFSC)*: _____

Combat specialty: _____

Current Contact Information:

Phone: _____
Cell: _____
DSN: _____
Email: _____
Address: _____

Point of Contact who can always reach you:

Name: _____
Phone: _____
Email: _____
Mailing Address: _____

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number:

1. Overall, how would you rate your health during the PAST MONTH?

- ○ Excellent
- ○ Very Good
- ○ Good
- ○ Fair
- ○ Poor

2. Compared to before this deployment, how would you rate your health in general now?

- ○ Much better now than before I deployed
- ○ Somewhat better now than before I deployed
- ○ About the same as before I deployed
- ○ Somewhat worse now than before I deployed
- ○ Much worse now than before I deployed

3. During the past 4 weeks, how difficult have physical health problems *(illness or injury)* **made it for you to do your work or other regular daily activities?**

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

4. During the past 4 weeks, how difficult have emotional problems *(such as feeling depressed or anxious)* **made it for you to do your work, take care of things at home, or get along with other people?**

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

5. How many times were you seen by a healthcare provider *(physician, PA, medic, corpsman, etc.)* **for a medical problem or concern during this deployment?**

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

- ○ No
- ○ Yes. Reason/dates:

7. Were you wounded, injured, assaulted or otherwise hurt during this deployment?

- ○ No
- ○ Yes

7a. IF YES, are you still having problems related to this event?

- ○ No
- ○ Yes
- ○ Unsure

8. For any of the following symptoms, please indicate whether you went to see a healthcare provider *(physician, PA, medic, corpsman, etc.)***, were placed on quarters** *(Qtrs)* **or given light/limited duty** *(Profile)***, and whether you are still bothered by the symptom now.**

Symptom	Sick Call?		Qtrs/Profile?		Still Bothered?		Symptom	Sick Call?		Qtrs/Profile?		Still Bothered?	
	No	Yes	No	Yes	No	Yes		No	Yes	No	Yes	No	Yes
Fever	○	○	○	○	○	○	Dizzy, light headed, passed out	○	○	○	○	○	○
Cough lasting more than 3 weeks	○	○	○	○	○	○	Diarrhea	○	○	○	○	○	○
Trouble breathing	○	○	○	○	○	○	Vomiting	○	○	○	○	○	○
Bad headaches	○	○	○	○	○	○	Frequent indigestion/ heartburn	○	○	○	○	○	○
Generally feeling weak	○	○	○	○	○	○	Problems sleeping or still feeling tired after sleeping	○	○	○	○	○	○
Muscle aches	○	○	○	○	○	○	Trouble concentrating, easily distracted	○	○	○	○	○	○
Swollen, stiff or painful joints	○	○	○	○	○	○	Forgetful or trouble remembering things	○	○	○	○	○	○
Back pain	○	○	○	○	○	○	Hard to make up your mind or make decisions	○	○	○	○	○	○
Numbness or tingling in hands or feet	○	○	○	○	○	○	Increased irritability	○	○	○	○	○	○
Trouble hearing	○	○	○	○	○	○	Skin diseases or rashes	○	○	○	○	○	○
Ringing in the ears	○	○	○	○	○	○	Other *(please list)*:	○	○	○	○	○	○
Watery, red eyes	○	○	○	○	○	○							
Dimming of vision, like the lights were going out	○	○	○	○	○	○							
Chest pain or pressure	○	○	○	○	○	○							

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number:

9.a. During this deployment, did you experience any of the following events? *(Mark all that apply)*

(1) Blast or explosion *(IED, RPG, land mine, grenade, etc.)*	○ No	○ Yes
(2) Vehicular accident/crash *(any vehicle, including aircraft)*	○ No	○ Yes
(3) Fragment wound or bullet wound above your shoulders	○ No	○ Yes
(4) Fall	○ No	○ Yes
(5) Other event *(for example, a sports injury to your head)*. Describe:	○ No	○ Yes

9.b. Did any of the following happen to you, or were you told happened to you, IMMEDIATELY after any of the event(s) you just noted in question 9.a.? *(Mark all that apply)*

(1) Lost consciousness or got "knocked out"	○ No	○ Yes
(2) Felt dazed, confused, or "saw stars"	○ No	○ Yes
(3) Didn't remember the event	○ No	○ Yes
(4) Had a concussion	○ No	○ Yes
(5) Had a head injury	○ No	○ Yes

9.c. Did any of the following problems begin or get worse after the event(s) you noted in question 9.a.? *(Mark all that apply)*

(1) Memory problems or lapses	○ No	○ Yes
(2) Balance problems or dizziness	○ No	○ Yes
(3) Ringing in the ears	○ No	○ Yes
(4) Sensitivity to bright light	○ No	○ Yes
(5) Irritability	○ No	○ Yes
(6) Headaches	○ No	○ Yes
(7) Sleep problems	○ No	○ Yes

9.d. In the past week, have you had any of the symptoms you indicated in 9.c.? *(Mark all that apply)*

(1) Memory problems or lapses	○ No	○ Yes
(2) Balance problems or dizziness	○ No	○ Yes
(3) Ringing in the ears	○ No	○ Yes
(4) Sensitivity to bright light	○ No	○ Yes
(5) Irritability	○ No	○ Yes
(6) Headaches	○ No	○ Yes
(7) Sleep problems	○ No	○ Yes

10. Did you encounter dead bodies or see people killed or wounded during this deployment? *(Mark all that apply)*
○ No ○ Yes (○ Enemy ○ Coalition ○ Civilian)

11. Were you engaged in direct combat where you discharged a weapon?
○ No ○ Yes (○ land ○ sea ○ air)

12. During this deployment, did you ever feel that you were in great danger of being killed?
○ No ○ Yes

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

a. Have had nightmares about it or thought about it when you did not want to?	○ No	○ Yes
b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?	○ No	○ Yes
c. Were constantly on guard, watchful, or easily startled?	○ No	○ Yes
d. Felt numb or detached from others, activities, or your surroundings?	○ No	○ Yes

14. Over the PAST MONTH, have you been bothered by the following problems?

	Not at all	Few or several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	○	○	○	○
b. Feeling down, depressed, or hopeless	○	○	○	○

15. Alcohol is occasionally available during deployments, e.g., R&R, port call, etc. Prior to deploying or during this deployment:

a. Did you use alcohol more than you meant to? ○ No ○ Yes

b. Have you felt that you wanted to or needed to cut down on your drinking? ○ No ○ Yes

c. How often do you have a drink containing alcohol?
○ Never ○ Monthly or less ○ 2 to 4 times a month ○ 2 to 3 times a week ○ 4 or more times a week

d. How many drinks containing alcohol do you have on a typical day when you are drinking?
○ 1 or 2 ○ 3 or 4 ○ 5 or 6 ○ 7 to 9 ○ 10 or more

e. How often do you have six or more drinks on one occasion?
○ Never ○ Less than monthly ○ Monthly ○ Weekly ○ Daily

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number:

16. Are you worried about your health because you were exposed to: *(Mark all that apply)*	No	Yes
Animal bites	○	○
Animal bodies *(dead)*	○	○
Chlorine gas	○	○
Depleted uranium *(If yes, explain)* _____	○	○
Excessive vibration	○	○
Fog oils (smoke screen	○	○
Garbage	○	○
Human blood, body fluids, body parts, or dead bodies	○	○
Industrial pollution	○	○
Insect bites	○	○
Ionizing radiation	○	○
JP8 or other fuels	○	○
Lasers	○	○
Loud noises	○	○
Paints	○	○
Pesticides	○	○
Radar/Microwaves	○	○
Sand/dust	○	○
Smoke from burning trash or feces	○	○
Smoke from oil fire	○	○
Solvents	○	○
Tent heater smoke	○	○
Vehicle or truck exhaust fumes	○	○
Other exposures to toxic chemicals or materials, such as ammonia, nitric acid, etc.: *(If yes, explain)* _____	○	○

17. Were you exposed to any chemicals or other hazard *(industrial, environmental, etc.)* **that required you to seek immediate medical care?**

○ No ○ Yes

18. Did you enter or closely inspect any destroyed military vehicles?

○ No ○ Yes

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

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

_____

20. This question assesses your personal risk for exposure to tuberculosis or other local infectious diseases. Would you say your INDOOR contact with local or 3rd country nationals was:

○ None ○ Minimal *(less than 1 hour per week)* ○ Moderate *(1 or more hours per week, but not daily)* ○ Extensive *(at least 1 hour per day, every day)*

21. Force Health Protection Measures. Please indicate which of the following items you used during this deployment and how often you used them.

	Daily	Most days	Some days	Never	Not available	Not required
DEET insect repellent applied to skin	○	○	○	○	○	○
Pesticide-treated uniforms	○	○	○	○	○	○
Eye protection *(not commercial sunglasses or prescription glasses)*	○	○	○	○	○	○
Hearing protection	○	○	○	○	○	○
N-95 or other respirator *(not gas mask)*	○	○	○	○	○	○
Pills to stay awake, like dexedrine	○	○	○	○	○	○
Anti-NBC meds	○	○	○	○	○	○
Pyridostigmine *(nerve agent pill)*	○	○	○	○	○	○
Nerve agent antidote injector	○	○	○	○	○	○
Seizure/convulsion antidote injector	○	○	○	○	○	○
NBC gas mask	○	○	○	○	○	○
MOPP over garments	○	○	○	○	○	○

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number:

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

- ○ Smallpox *(leaves a scar on the arm)*
- ○ Anthrax
- ○ Botulism
- ○ Typhoid
- ○ Meningococcal
- ○ Yellow Fever
- ○ Other, list: _____
- ○ No
- ○ Don't know

23. Were you told to take medicines to prevent malaria?

○ No ○ Yes

If YES, please indicate which medicines you took and whether you missed any doses. *(Mark all that apply)*

Anti-malarial medications	Took All Pills
○ Chloroquine (Aralen®)	○ No ○ Yes
○ Doxycycline (Vibramycin®)	○ No ○ Yes
○ Mefloquine (Lariam®)	○ No ○ Yes
○ Primaquine	○ No ○ Yes
○ Other : _____	○ No ○ Yes

24. Would you like to schedule a visit with a healthcare provider to further discuss your health concern(s)? ○ No ○ Yes

25. Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern? ○ No ○ Yes

26. Are you currently interested in receiving assistance for a family or relationship concern? ○ No ○ Yes

27. Would you like to schedule a visit with a chaplain or a community support counselor? ○ No ○ Yes

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number:

Health Care Provider Only

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

1. Do you have any medical or dental problems that developed during this deployment? ○ Yes ○ No

If yes, are the problems still bothering you now? ○ Yes ○ No

2. Are you currently on a profile (or LIMDU) that restricts your activities (light or limited duty)? ○ Yes ○ No

If yes: For what reason? _____ ○ NA

Is your condition due to an injury or illness that occurred during the deployment? ○ Yes ○ No ○ NA

Did you have similar problems prior to deployment? ○ Yes ○ No ○ NA

If so, did your condition worsen during the deployment? ○ Yes ○ No ○ NA

3. Ask the following behavioral risk questions. Conduct risk assessment as necessary.

a. Over the PAST MONTH, have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way? ○ Yes ○ No

IF YES, about how often have you been bothered by these thoughts? ○ A few days ○ More than half of the time ○ Nearly every day

b. Over the PAST MONTH, have you had thoughts or concerns that you might hurt or lose control with someone? ○ Yes ○ No ○ Unsure

4. If member reports YES or UNSURE responses to 3.a. or 3.b., conduct risk assessment.

a. Does member pose a current risk for harm to self or others? ○ No, not a current risk ○ Yes, poses a current risk ○ Unsure

b. Outcome of assessment ○ Immediate referral ○ Routine follow-up referral ○ Referral not indicated

5. Alcohol screening result

○ No evidence of alcohol-related problems

○ Potential alcohol problem (positive response to either question 15.a. or 15.b. and/or AUDIT-C (questions 15.c.-e.) score of 4 or more for men or 3 or more for women).

Refer to PCM for evaluation. ○ Yes ○ No

6. During this deployment have you sought, or do you now intend to seek, counseling or care for your mental health? ○ Yes ○ No

7. Traumatic Brain Injury (TBI) risk assessment

○ No evidence of risk based on responses to questions 9.a. - d.

○ Potential TBI with persistent symptoms, based on responses to question 9.d.

Refer for additional evaluation. ○ Yes ○ No

8. Tuberculosis risk assessment, based on response to question 20.

○ Minimal risk

○ Increased risk

Recommend tuberculosis skin testing in 60-90 days ○ Yes ○ No

9. Depleted Uranium (DU) risk assessment, based on responses to question 16 (DU, Yes) or question 18 (Yes).

○ No evidence of exposure to depleted uranium

○ Potential exposure to depleted uranium

Refer to PCM for completion of DD Form 2872 and possible 24-hour urinalysis. ○ Yes ○ No

10. Do you have any other concerns about possible exposures or events during this deployment that you feel may affect your health? ○ Yes ○ No

Please list your concerns: _____

_____

_____

11. Do you currently have any questions or concerns about your health? ○ Yes ○ No

Please list your concerns: _____

_____

_____

This form must be completed electronically. Handwritten forms will not be accepted.

Service Member's Social Security Number:

Health Assessment

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

11. Identified Concerns	Minor Concern	Major Concern	Already Under Care	
			Yes	No
○ Physical Symptom(s)	○	○	○	○
○ Exposure Symptom(s)	○	○	○	○
○ Environmental	○	○	○	○
○ Occupational	○	○	○	○
○ Combat or mission-related	○	○	○	○
○ Depression symptoms	○	○	○	○
○ PTSD symptoms	○	○	○	○
○ Anger/Aggression	○	○	○	○
○ Suicidal Ideation	○	○	○	○
○ Social/Family Conflict	○	○	○	○
○ Alcohol Use	○	○	○	○
○ Other: _____	○	○	○	○

12. Referral Information	Within 24 hours	Within 7 days	Within 30 days
a. Primary Care, Family Practice	○	○	○
b. Behavioral Health in Primary Care	○	○	○
c. Mental Health Specialty Care	○	○	○
d. Other specialty care:			
Audiology	○	○	○
Cardiology	○	○	○
Dentistry	○	○	○
Dermatology	○	○	○
ENT	○	○	○
GI	○	○	○
Internal Medicine	○	○	○
Neurology	○	○	○
OB/GYN	○	○	○
Ophthalmology	○	○	○
Optometry	○	○	○
Orthopedics	○	○	○
Pulmonology	○	○	○
Urology	○	○	○
e. Case Manager, Care Manager	○	○	○
f. Substance Abuse Program	○	○	○
g. Health Promotion, Health Education	○	○	○
h. Chaplain	○	○	○
i. Family Support, Community Service	○	○	○
j. Military OneSource	○	○	○
k. Other: _____	○	○	○
l. No referral made ○			

13. Comments:

I certify that this review process has been completed.

Provider's signature and stamp:

This visit is coded by V70.5 _ E

Date *(dd/mmm/yyyy)*

S A M P L E

Ancillary Staff/Administrative Section

14. Member was provided the following:	15. Referral was made to the following healthcare or support system:
○ Medical Threat Debrief	○ Military Treatment Facility
○ Health Education and Information	○ Division/Line-based medical resource
○ Health Care Benefits and Resources Information	○ VA Medical Center or Community Clinic
○ Appointment Assistance	○ Vet Center
○ Service member declined to complete form	○ TRICARE Provider
○ Service member declined to complete interview/assessment	○ Contract Support: _____
○ Service member declined referral for services	○ Community Service: _____
○ LOD	○ Other: _____
○ Post-deployment blood specimen collected (if required)	○ None
○ Other: _____	