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

PRE-DEPLOYMENT HEALTH ASSESSMENT

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting the personal information required by the DD Form 2795, Pre-Deployment Health Assessment, and how it will be used.

AUTHORITY: 10 U.S.C. 136, Under Secretary of Defense for Personnel and Readiness; 10 U.S.C. 1074f, Medical Tracking System for Members Deployed Overseas; DoDD 1404.10, DoD Civilian Expeditionary Workforce; DoDD 6490.02E, Comprehensive Health Surveillance; and E.O. 9397 (SSN), as amended.

PURPOSE: To collect information on your physical and mental health status prior to a deployment in a combat, contingency, or other operation outside of the United States, and to assist health care providers in administering present or future care.

ROUTINE USES: Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at http://dpcld.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx, and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary. However, if you choose not to provide the requested information comprehensive health care services may not be possible or administrative delays may occur. Care will not be denied.

INSTRUCTIONS: You are encouraged to answer all questions. You must at least complete the first portion on who you are and when you will deploy. If you do not understand a question, please discuss the question with a health care provider.

DEMOGRAPHICS

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

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

Date of Birth (*dd/mmm/yyyy*) _____ **Sex** O Male O Female

Service Branch
- O Air Force
- O Army
- O Navy
- O Marine Corps
- O Coast Guard
- O Civilian Expeditionary Workforce (CEW)
- O USPHS
- O Other Defense Agency List: _____

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

Pay Grade

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

Current contact information:

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

Point of contact who can always reach you:

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

Estimated date of upcoming deployment (*dd/mmm/yyyy*) _____

List country you are deploying to (if known): _____

Name of operation (if known): _____

How many deployments have you done before? O None O 1 O 2 O 3 O 4 O 5 O 6 or more

(if previous question was answered as one or more)
When did you return from your last deployment? (*Mmm yyyy*) _____

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

Deployer's SSN (Last 4 digits): _____

1. **Overall, how would you rate your health during the PAST MONTH?**
   O Excellent O Very Good O Good O Fair O Poor

2. **Are you CURRENTLY on a profile, limited duty, waiting on a MOS/Medical Retention Board (MMRB) decision, or being referred to a medical evaluation board (MEB) or physical evaluation board (PEB)?**
   O Yes For what reason? _____
   O No
   O Don't know

3. **How often do you smoke tobacco (for example cigarettes, cigars, pipe or hookah)?**
   O Just about every day
   O Some days
   O Not at all

4. **What problems, questions or concerns do you have about your medical, dental, or mental health?**
   O Please explain: _____
   O None

5. **FEMALES ONLY – Are you pregnant or is there a chance you could be pregnant?**
   O Don't know
   O Yes
   O No

6. **In the PAST YEAR did you receive care for a head injury?**
   O Yes Please explain: _____
   O No

7. **What prescription or over-the- counter medications (including herbals/supplements) for sleep, pain, combat stress, or mental health conditions or concerns are you CURRENTLY taking?**
   O Please list: _____
   _____
   O None

8. **In the PAST YEAR did you receive care for any mental health condition or concern such as, but not limited to post traumatic stress disorder (PTSD),depression, anxiety disorder, alcohol abuse or substance abuse?**
   O Yes Please explain: _____
   O No

9. **During the PAST MONTH, how much have you been bothered by any of the following problems?**

Symptom	Not bothered at all	Bothered a little	Bothered a lot
a. Noises in your head or ears (such as ringing, buzzing, crickets, humming, tone, etc.)	O	O	O
b. Trouble hearing	O	O	O

10. a. **How often do you have a drink containing alcohol?**
    O Never O Monthly or less O 2-4 times a month O 2-3 times per week O 4 or more times a week

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

    c. **How often do you have six or more drinks on one occasion?**
    O Never O Less than monthly O Monthly O Weekly O Daily or almost daily

11. **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? O Yes O No
    b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it? O Yes O No
    c. Were constantly on guard, watchful or easily startled? O Yes O No
    d. Felt numb or detached from others, activities, or your surroundings? O Yes O No

NOTE: If 2 or more items on 11a. through 11d. are marked yes, continue to answer items 11e. through 11v.

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

Deployer's SSN (Last 4 digits): _____

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each question carefully and check the box for how much you have been bothered by that problem in the PAST MONTH. Please answer all items.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
11e. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	O	O	O	O	O
11f. Repeated, disturbing dreams of a stressful experience from the past?	O	O	O	O	O
11g. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	O	O	O	O	O
11h. Feeling very upset when something reminded you of a stressful experience from the past?	O	O	O	O	O
11i. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	O	O	O	O	O
11j. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	O	O	O	O	O
11k. Avoid activities or situations because they remind you of a stressful experience from the past?	O	O	O	O	O
11l. Trouble remembering important parts of a stressful experience from the past?	O	O	O	O	O
11m. Loss of interest in things that you used to enjoy?	O	O	O	O	O
11n. Feeling distant or cut off from other people?	O	O	O	O	O
11o. Feeling emotionally numb or being unable to have loving feelings for those close to you?	O	O	O	O	O
11p. Feeling as if your future will somehow be cut short?	O	O	O	O	O
11q. Trouble falling or staying asleep?	O	O	O	O	O
11r. Feeling irritable or having angry outbursts?	O	O	O	O	O
11s. Having difficulty concentrating?	O	O	O	O	O
11t. Being "super alert" or watchful, on guard?	O	O	O	O	O
11u. Feeling jumpy or easily startled?	O	O	O	O	O

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
11v. How difficult have these problems (11e. through 11u) made it for you to do your work, take care of things at home, or get along with other people?	O	O	O	O

12. Over the LAST 2 WEEKS, how often 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	O	O	O	O
b. Feeling down, depressed, or hopeless	O	O	O	O

NOTE: If 12a. or 12b. are marked "More than half the days" or "Nearly every day," continue to answer items 12c. through 12i.

Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?	Not at all	Few or several days	More than half the days	Nearly every day
12c. Trouble falling/staying asleep, sleep too much.	O	O	O	O
12d. Feeling tired or having little energy.	O	O	O	O
12e. Poor appetite or overeating.	O	O	O	O
12f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	O	O	O	O
12g. Trouble concentrating on things, such as reading the newspaper or watching television.	O	O	O	O
12h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety that you have been moving around a lot more than usual.	O	O	O	O

	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
12i. How difficult have these problems (12a.through12h.) made it for you to do your work, take care of things at home, or get along with other people?	O	O	O	O

13. a. Over the PAST MONTH, what major life stressors have you experienced that are a cause of significant concern or make it difficult for you to do your work, take care of things at home, or get along with other people (for example, serious conflicts with others, relationship problems, or a legal, disciplinary or financial problem)?

O None or
O Please list and explain: _____

_____

_____

b. Are you currently in treatment or getting professional help for this concern?

O Yes O No

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

Deployer's SSN (Last 4 digits): _____

Health Care Provider Only – Provider Review, Interview, Assessment, and Recommendations:

Deployer is deploying to _____. Has deployed _____ times before. Last returned _____

1. Address concerns identified on deployer questions 1 through 8.

Deployer question	Not answered	Deployer indicated concern or yes	Deployer's response	Provider comments (if indicated)
Self health rating	O	O		
MEB or PEB	O	O		
Medical, dental, or mental health concern	O	O		
Pregnancy	O	O		
Head injury	O	O		
Medications	O	O		
History of mental health care	O	O		

2. Hearing and tinnitus as reported in deployer question 9.

a. Did deployer mark he/she bothered a little or a lot in the past month by "noises in head or ears" or "trouble hearing"?
O Yes
O No (*go to block 3)*

b. If yes, referral indicated?
O Yes (complete blocks 11 and 12)
O No
O *Already under care*
O *Already has referral*
O *No significant impairment*
O *Other reason (explain):* _____

3. Alcohol use as reported in deployer question 10.

a. Deployer's AUDIT-C screening score was _____. *(If score between 0-4 (men) or 0-3 (women) nothing required, go to block 4).*
O Not answered

Number of drinks per week: _____ Maximum number of drinks per occasion: _____

Based on the AUDIT-C score and assessment of alcohol use, follow the guidance below:

Alcohol Use Intervention Matrix		
Assess Alcohol Use	AUDIT-C Score Men 5-7 Women 4-7	AUDIT-C Score Men and Women ≥ 8
Alcohol use WITHIN recommended limits: Men: ≤ 14 drinks per week **OR** ≤ 4 drinks on any occasion Women: ≤ 7 drinks per week **OR** ≤ 3 drinks on any occasion	Advise patient to stay below recommended limits	Refer if indicated for further evaluation AND conduct BRIEF counseling*
Alcohol use EXCEEDS recommended limits: Men: > 14 drinks per week or > 4 drinks on any occasion Women: > 7 drinks per week or > 3 drinks on any occasion	Conduct BRIEF counseling* AND consider referral for further evaluation	

* **BRIEF** counseling**: B**ring attention to elevated level of drinking; **R**ecommend limiting use or abstaining; **I**nform about the effects of alcohol on health; **E**xplore and help/support in choosing a drinking goal; **F**ollow-up referral for specialty treatment, if indicated.

b. Referral indicated for evaluation?
O Yes (complete blocks 11 and 12)
O No Provide education/awareness as needed.
State reason if AUDIT-C score was 8+:
O *Already under care*
O *Already has referral*
O *No significant impairment*
O *Other reason (explain):* _____

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

Deployer's SSN (Last 4 digits): _____

4. PTSD screening as reported in deployer question 11.

a. Did deployer mark yes on two or more of questions 11a. through 11d.?

- O Yes
- O No (go to block 5)
- O Not answered by deployer

b. If yes, deployer's responses to questions 11e. through 11u. resulted in a PCL-C score of _____ and the deployer's response to level of impairment with life events (11v.) is indicated in the table below.

O 11e. through 11v. were not answered or are incomplete.

Based on the PCL-C score, the deployer's level of functioning, and your exploration of responses, follow the guidance below:

Post-Traumatic Stress Disorder Intervention Matrix				
Self-Reported Level of Functioning	PCL-C Score <30 (Sub-threshold or no Symptoms)	PCL-C Score 30-39 (Mild Symptoms)	PCL-C Score 40-49 (Moderate Symptoms)	PCL-C Score ≥ 50 (Severe Symptoms)
O **Not Difficult at All or Somewhat Difficult**	No intervention	Provide PTSD education*		Consider referral for further evaluation AND provide PTSD education*
O **Very Difficult to Extremely Difficult**	Assess need for further evaluation AND provide PTSD education*	Consider referral for further evaluation AND provide PTSD education*		Refer for further evaluation AND provide PTSD education*

* PTSD Education = Reassurance/supportive counseling, provide literature on PTSD, encourage self-management activities, and counsel deployer to seek help for worsening symptoms.

c. Referral indicated?

- O Yes (complete blocks 11 and 12)
- O No
  - O *Already under care*
  - O *Already has referral*
  - O *No significant impairment*
  - O *Other reason (explain):* _____

5. Depression screening as reported in deployer question 12.

a. Did deployer mark "More than half the days" or "Nearly every day" on question 12a. or 12b.?

- O Yes
- O No (go to block 6)
- O Not answered by deployer

b. If yes, deployer's responses to questions 12a. through 12h. resulted in a total PHQ-8 score of _____ and the deployer's response to level of impairment with life events (12i.) is indicated in the table below.

O 12c. through 12i. were not answered or incomplete.

Based on the PHQ-8 score, deployer's level of functioning, and exploration of responses, follow the guidance below:

Depression Intervention Matrix					
Self-Reported Level of Functioning	PHQ-8 Score 1-4 (No Symptoms)	PHQ-8 Score 5-9 (Sub-Threshold Symptoms)	PHQ-8 Score 10-14 (Mild Symptoms)	PHQ-8 Score 15-18 (Moderate Symptoms)	PHQ-8 Score 19-24 (Severe Symptoms)
O **Not Difficult at All or Somewhat Difficult**	No intervention	Depression education*		Consider referral for further evaluation AND provide depression education*	Consider referral for further evaluation AND provide depression education*
O **Very Difficult to Extremely Difficult**	Assess need for further evaluation AND provide depression education*		Consider referral for further evaluation AND provide depression education*	Consider referral for further evaluation AND provide depression education*	Refer for further evaluation AND provide depression education*

* Depression Education = Reassurance/supportive counseling, provide literature on depression, encourage self-management activities, and counsel deployer to seek help for worsening symptoms.

c. Referral indicated?

- O Yes (complete blocks 11 and 12)
- O No
  - O *Already under care*
  - O *Already has referral*
  - O *No significant impairment*
  - O *Other reason (explain):* _____

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

Deployer's SSN (Last 4 digits): _____

6. Major life stressor as reported on deployer question 13.

a. Did deployer mark they have a concern or a difficulty with a major life stressor?
- O Yes Deployer's concern: _____
- O No (*go to block 7)*
- O Not answered by deployer

b. If yes, **ask** additional questions to determine level of problem: _____

c. Consider need for referral. Referral indicated?
- O Yes (complete blocks 11 and 12)
- O No
  - O *Already under care*
  - O *Already has referral*
  - O *No significant impairment*
  - O Other *reason (explain):* _____

7. Suicide risk evaluation.

a. **Ask** "Over the **PAST MONTH**, have you been bothered by thoughts that you would be better off dead or of hurting yourself in some way?"
- O Yes
- O No (go to block 8)

b. If 7.a. was yes, **ask:** "How often have you been bothered by these thoughts?"
- O Few or several days
- O More than half of the time
- O Nearly every day

c. If 7.a. was yes, **ask:** "Have you had thoughts of actually hurting yourself?"
- O Yes **(If yes ask questions 7d. through 7g.)**
- O No (If no thoughts of self-harm, go to block 8)

d. **Ask** "Have you thought about how you might actually hurt yourself?"
- O Yes How? _____
- O No

e. **Ask** "There's a big difference between having a thought and acting on a thought. How likely do you think it is that you will act on these thoughts about hurting yourself or ending your life over the next month?"
- O Not at all likely
- O Somewhat likely
- O Very likely

f. **Ask** "Is there anything that would prevent or keep you from harming yourself?"
- O Yes What? _____
- O No

g. **Ask** "Have you ever attempted to harm yourself in the past?"
- O Yes How? _____
- O No

h. Conduct further risk assessment (e.g., interpersonal conflicts, social isolation, alcohol/substance abuse, hopelessness, severe agitation/anxiety, diagnosis of depression or other psychiatric disorder, recent loss, financial stress, legal disciplinary problems, or serious physical illness).

Comments: _____

_____

i. Does deployer pose a current risk for harm to self?
- O Yes (complete blocks 11 and 12)
- O No

8. Violence/harm risk evaluation.

a. **Ask,** "Over the past month have you had thoughts or concerns that you might hurt or lose control with someone?"
- O Yes
- O No *(go to block 9)*

If yes, **ask** additional questions to determine extent of problem (target, plan, intent, past history) Comments: _____

b. Does member pose a current risk to others?
- O Yes (complete blocks 11 and 12)
- O No (briefly state reason): _____

9. Medical History Review – if available, hard copy and/or electronic health records (including DD2766 and SF-600 entries, and most recent past deployment health assessments).
- O Completed
- O No health records available

a. Significant findings related to ability to deploy: _____

_____

_____

b. Evidence of deployment limiting conditions or medications?
- O Yes
- O No

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

Deployer's SSN (Last 4 digits): _____

10. Deployer issues with this assessment (mark as appropriate):
O Deployer declined to complete form
O Deployer declined to complete interview/assessment

Assessment and Referral: After review of deployer's responses and interview with the deployer, the assessment and need for further evaluation is indicated in blocks 11 through 14.

11. Summary of provider's identified concerns needing referral < Mark all that apply>	Yes	No
a. None Identified O		
b. Physical health	O	O
c. Dental health	O	O
d. Alcohol use	O	O
e. PTSD symptoms	O	O
f. Depression symptoms	O	O
g. Mental health symptoms	O	O
h. Risk of self-harm	O	O
i. Risk of violence	O	O
j. Other, list:	O	O

12. Recommended referral(s) < Mark all that apply even if deployer does not desire>	Within 24 hours	Within 7 days	Within 30 days
a. Primary Care, Family Practice, Internal Medicine	O	O	O
b. Behavioral Health in Primary Care	O	O	O
c. Mental Health Specialty Care	O	O	O
d. Dental	O	O	O
e. Other specialty care:	O	O	O
Audiology	O	O	O
Dermatology	O	O	O
OB/GYN	O	O	O
Physical Therapy	O	O	O
TBI/Rehab Med	O	O	O
Podiatry	O	O	O
Other, list	O	O	O
f. Case Manager / Care Manager	O	O	O
g. Substance Abuse Program	O	O	O
h. Immunization Clinic	O	O	O
i. Laboratory	O	O	O
j. Other, list:	O	O	O

S A M P L E

13. Comments: _____

14. Medical assessment/disposition:
O Deployable
O Deployable at present, but requires medical readiness updates. May delay or make undeployable, e.g., pregnancy test, immunizations, overdue Pap test, dental exam, PHA, outdated eyeglass prescription, (add comments – block 15).
O Not Deployable – potentially disqualifying condition requiring additional evaluation (add comments – block 15).
O Not Deployable – other (add comments – block 15).

15. Comments (Mandatory for any type of Not Deployable disposition).

_____

_____

16. Supplemental services recommended / information provided	
O Appointment Assistance	O Family Support
O Contract Support: _____	O Military One Source
O Community Service: _____	O TRICARE Provider
O Chaplain	O VA Medical Center or Community Clinic
O Health Education and Information	O Vet Center
O Health Care Benefits and Resources Information	O Other, list:
O In Transition	

Provider's Name: _____ Date (*dd/mmm/yyyy*) _____

Title: O MD or DO O PA O Nurse Practitioner O Adv Practice Nurse O IDMT O IDC O IDHS

I certify that this review process has been completed. **This visit is coded by DOD0211.**