

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://dpcl.dod.mil/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) _____ Gender Male Female

Service Branch	Component	Pay Grade		
<input type="radio"/> Air Force	<input type="radio"/> Active Duty	<input type="radio"/> E1	<input type="radio"/> O1	<input type="radio"/> W1
<input type="radio"/> Army	<input type="radio"/> National Guard	<input type="radio"/> E2	<input type="radio"/> O2	<input type="radio"/> W2
<input type="radio"/> Navy	<input type="radio"/> Reserves	<input type="radio"/> E3	<input type="radio"/> O3	<input type="radio"/> W3
<input type="radio"/> Marine Corps	<input type="radio"/> Civilian Government Employee	<input type="radio"/> E4	<input type="radio"/> O4	<input type="radio"/> W4
<input type="radio"/> Coast Guard		<input type="radio"/> E5	<input type="radio"/> O5	<input type="radio"/> W5
<input type="radio"/> Civilian Expeditionary Workforce (CEW)		<input type="radio"/> E6	<input type="radio"/> O6	
<input type="radio"/> USPHS		<input type="radio"/> E7	<input type="radio"/> O7	<input type="radio"/> Other
<input type="radio"/> Other Defense Agency List: _____		<input type="radio"/> E8	<input type="radio"/> O8	

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? None 1 2 3 4 5 6 or more

(if previous question was answered as one or more)

When did you return from your last deployment? (Mmm yyyy) _____

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Deployer's SSN (Last 4 digits): _____

1. Overall, how would you rate your health during the PAST MONTH?
 Excellent Very Good Good Fair 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)?
 Yes For what reason? _____
 No
 Don't know
3. How often do you smoke tobacco (for example cigarettes, cigars, pipe or hookah)?
 Just about every day
 Some days
 Not at all
4. What problems, questions or concerns do you have about your medical, dental, or mental health?
 Please explain: _____
 None
5. FEMALEs ONLY – Are you pregnant or is there a chance you could be pregnant?
 Don't know
 Yes
 No
6. In the PAST YEAR did you receive care for a head injury?
 Yes Please explain: _____
 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?
 Please list: _____
 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?
 Yes Please explain: _____
 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.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Trouble hearing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. a. How often do you have a drink containing alcohol?
 Never Monthly or less 2-4 times a month 2-3 times per week 4 or more times a week
b. 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
c. How often do you have six or more drinks on one occasion?
 Never Less than monthly Monthly Weekly 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?
 Yes No
b. Tried hard not to think about it or went out of your way to avoid situations that remind you of it?
 Yes No
c. Were constantly on guard, watchful or easily startled?
 Yes No
d. Felt numb or detached from others, activities, or your surroundings?
 Yes No

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

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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?	<input type="radio"/>				
11f. Repeated, disturbing dreams of a stressful experience from the past?	<input type="radio"/>				
11g. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?	<input type="radio"/>				
11h. Feeling very upset when something reminded you of a stressful experience from the past?	<input type="radio"/>				
11i. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?	<input type="radio"/>				
11j. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?	<input type="radio"/>				
11k. Avoid activities or situations because they remind you of a stressful experience from the past?	<input type="radio"/>				
11l. Trouble remembering important parts of a stressful experience from the past?	<input type="radio"/>				
11m. Loss of interest in things that you used to enjoy?	<input type="radio"/>				
11n. Feeling distant or cut off from other people?	<input type="radio"/>				
11o. Feeling emotionally numb or being unable to have loving feelings for those close to you?	<input type="radio"/>				
11p. Feeling as if your future will somehow be cut short?	<input type="radio"/>				
11q. Trouble falling or staying asleep?	<input type="radio"/>				
11r. Feeling irritable or having angry outbursts?	<input type="radio"/>				
11s. Having difficulty concentrating?	<input type="radio"/>				
11t. Being "super alert" or watchful, on guard?	<input type="radio"/>				
11u. Feeling jumpy or easily startled?	<input type="radio"/>				
	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

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
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
a. Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12d. Feeling tired or having little energy.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12e. Poor appetite or overeating.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12g. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
12i. How difficult have these problems (12a. through 12h.) made it for you to do your work, take care of things at home, or get along with other people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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)?

None or
 Please list and explain: _____

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

Yes No

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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	<input type="radio"/>	<input type="radio"/>		
MEB or PEB	<input type="radio"/>	<input type="radio"/>		
Medical, dental, or mental health concern	<input type="radio"/>	<input type="radio"/>		
Pregnancy	<input type="radio"/>	<input type="radio"/>		
Head injury	<input type="radio"/>	<input type="radio"/>		
Medications	<input type="radio"/>	<input type="radio"/>		
History of mental health care	<input type="radio"/>	<input type="radio"/>		

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"? Yes
 No (go to block 3)

b. If yes, referral indicated? Yes (complete blocks 11 and 12)
 No
 Already under care
 Already has referral
 No significant impairment
 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). 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: \leq 14 drinks per week <u>OR</u> \leq 4 drinks on any occasion Women: \leq 7 drinks per week <u>OR</u> \leq 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: Bring attention to elevated level of drinking; Recommend limiting use or abstaining; Inform about the effects of alcohol on health; Explore and help/support in choosing a drinking goal; Follow-up referral for specialty treatment, if indicated.

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

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4. PTSD screening as reported in deployer question 11.

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

Yes
 No (go to block 5)
 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.

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)
<input type="radio"/> Not Difficult at All or Somewhat Difficult	No intervention	Provide PTSD education*		Consider referral for further evaluation AND provide PTSD education*
<input type="radio"/> 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?

Yes (complete blocks 11 and 12)
 No *Already under care*
 Already has referral
 No significant impairment
 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.?

Yes
 No (go to block 6)
 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.

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)
<input type="radio"/> 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*
<input type="radio"/> 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?

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

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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? _____

Yes Deployer's concern: _____
 No (go to block 7)
 Not answered by deployer

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

c. Consider need for referral. Referral indicated? _____

Yes (complete blocks 11 and 12)
 No Already under care
 Already has referral
 No significant impairment
 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?" _____

Yes
 No (go to block 8)

b. If 7.a. was yes, **ask**: "How often have you been bothered by these thoughts?" _____

Few or several days
 More than half of the time
 Nearly every day

c. If 7.a. was yes, **ask**: "Have you had thoughts of actually hurting yourself?" _____

Yes (If yes ask questions 7d. through 7g.)
 No (if no thoughts of self-harm, go to block 8)

d. **Ask** "Have you thought about how you might actually hurt yourself?" _____

Yes How? _____
 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?" _____

Not at all likely
 Somewhat likely
 Very likely

f. **Ask** "Is there anything that would prevent or keep you from harming yourself?" _____

Yes What? _____
 No

g. **Ask** "Have you ever attempted to harm yourself in the past?" _____

Yes How? _____
 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). _____

i. Does deployer pose a current risk for harm to self? _____

Yes (complete blocks 11 and 12)
 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?" _____

Yes
 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? _____

Yes (complete blocks 11 and 12)
 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).

a. Significant findings related to ability to deploy: _____

b. Evidence of deployment limiting conditions or medications? _____

Yes
 No

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10. Deployer issues with this assessment (mark as appropriate):	
<input type="radio"/> Deployer declined to complete form	
<input type="radio"/> 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	<input type="radio"/>	<input checked="" type="radio"/>
b. Physical health	<input type="radio"/>	<input type="radio"/>
c. Dental health	<input type="radio"/>	<input type="radio"/>
d. Alcohol use	<input type="radio"/>	<input type="radio"/>
e. PTSD symptoms	<input type="radio"/>	<input type="radio"/>
f. Depression symptoms	<input type="radio"/>	<input type="radio"/>
g. Mental health symptoms	<input type="radio"/>	<input type="radio"/>
h. Risk of self-harm	<input type="radio"/>	<input type="radio"/>
i. Risk of violence	<input type="radio"/>	<input type="radio"/>
j. Other, list:	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Behavioral Health in Primary Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Mental Health Specialty Care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Dental	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Other specialty care:			
Audiology	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dermatology	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OB/GYN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical Therapy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TBI/Rehab Med	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Podiatry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, list	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Case Manager / Care Manager	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Substance Abuse Program	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Immunization Clinic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Laboratory	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Other, list:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

13. Comments: _____

14. Medical assessment/disposition:

- Deployable
- 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).
- Not Deployable – potentially disqualifying condition requiring additional evaluation (add comments – block 15).
- Not Deployable – other (add comments – block 15).

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

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

Provider's Name: _____

Date (dd/mmm/yyyy) _____

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

I certify that this review process has been completed.

This visit is coded by DOD0211.