





33823

PLEASE FILL IN SOCIAL SECURITY #

SSN input boxes: [ ][ ][ ] - [ ][ ] - [ ][ ][ ][ ]

**Health Assessment**

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

Please list your concerns:

\_\_\_\_\_

\_\_\_\_\_

Service Member Signature

I certify that responses on this form are true.

Signature box

**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**

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

**FINAL MEDICAL DISPOSITION:**

- Deployable
- Not Deployable

Comments: (If not deployable, explain)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that this review process has been completed.

Provider's signature and stamp:

Signature box

Date (dd/mm/yyyy)

Date input boxes: [ ][ ] / [ ][ ] / [ ][ ][ ][ ]

**End of Health Review**

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