

PROTECTING THE HEALTH OF SERVICE MEMBERS AND VETERANS



The Millennium Cohort Study



PLEASE COMPLETE THIS
SURVEY AND RETURN IT IN
THE PRE-PAID ENVELOPE

OR

GO TO WWW.MILLENNIUMCOHORT.ORG
CLICK "START SURVEY"
ENTER YOUR SUBJECT ID:

PRIVACY ACT STATEMENT:

You have rights under the Privacy Act. The following statement describes how that Act applies to this study:

Authority: Authority to request this information is granted under Title 5, U.S. Code 136, Department of Defense Regulations, Executive Order 9396, DoD RCS#DD-HA(AR)2106 (expires XX/XX/20XX), and OMB #0720-0029 (expires XX/XX/20XX). Personal identifiers will be used to link survey data with medical and other military records.

Purpose: Medical research information will be collected in a research project titled "Prospective Studies of U.S. Military Forces: The Millennium Cohort Study." The project objective is to enhance basic medical knowledge and to improve the treatment and prevention of illnesses that may be related to military service.

Routine Uses: The information provided in this questionnaire will be maintained in data files at the Deployment Health Research Department at the Naval Health Research Center and used only for medical research purposes. Use of these data may be granted to other federal and non-federal medical research agencies as approved by the Naval Health Research Center's Institutional Review Board. However, your personal identifiers will be protected. By signing the original consent form, you volunteered to disclose your information as identified above. If you do not agree to this disclosure, your failure will make the research less useful. The "Blanket Routine Uses" that appears at the beginning of the Department of Defense's compilation of medical databases also applies to this system.

Anonymity: All responses will be held in confidence by the Deployment Health Research Department. Information you provide will be considered only when statistically summarized with the responses of others. Your personal identifiers (name, etc.) will only be used to link data sets and then the identifiers will be stripped from study data such that medical researchers cannot identify you individually.

Voluntary Disclosure: Completion of the questionnaire is voluntary. Failure to respond to any of the questions will NOT result in any penalties except possible lack of representation of your views in the final results and outcomes.

PUBLIC BURDEN STATEMENT: The public reporting burden for this collection of information is estimated to average 45 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Washington Headquarters Services, Executive Services Directorate, Information Management Division, 4800 Mark Center Drive, East Tower, Suite 02G09, Alexandria, VA 22350-3100 (0720-0029) Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

MARKING INSTRUCTIONS

- Use blue or black ink.
- Shade circles like this. ●
- Include additional comments in the open text field on the last page.

1. In general would you say your health is: (Please select only one)

- Excellent Very good Good Fair Poor

2. The following questions are about activities you might do during a **typical day**. Does **your health now limit you** in these activities? If so, how much?

	No, not limited at all	Yes, limited a little	Yes, limited a lot
a. Vigorous activities , such as running, lifting heavy objects, or participating in strenuous sports	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Lifting or carrying groceries	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Climbing several flights of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Climbing one flight of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Bending, kneeling, or stooping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Walking more than a mile	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Walking several blocks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Walking one block	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Bathing or dressing yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

	No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all of the time
a. Cut down the amount of time you spent on work or other activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Accomplished less than you would like	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Were limited in the kind of work or other activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Had difficulty performing the work or other activities (for example, it took extra effort)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

4. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)?

	No, none of the time	Yes, a little of the time	Yes, some of the time	Yes, most of the time	Yes, all of the time
a. Cut down the amount of time you spent on work or other activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Accomplished less than you would like	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Didn't do work or other activities as carefully as usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

5. During the **past 4 weeks**, to what extent has your **physical health** or **emotional problems** interfered with your normal social activities with family, friends, neighbors, or groups?
 Not at all Slightly Moderately Quite a bit Extremely

6. During the **past 4 weeks**, how much bodily pain have you had?
 None Very mild Mild Moderate Severe Very severe

7. During the **past 4 weeks**, how much did **pain** interfere with your normal work (including both work outside the home and housework)?
 Not at all A little bit Moderately Quite a bit Extremely

8. During the **past 4 weeks**, how much of the time:
 (Select the **single best** answer for each question)

	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
a. Did you feel full of pep ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Have you been a very nervous person ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Have you felt so down in the dumps that nothing could cheer you up ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Have you felt calm and peaceful ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Did you have a lot of energy ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Have you felt downhearted and blue ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Did you feel worn out ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Have you been a happy person ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Did you feel tired ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. During the **past 4 weeks**, how much of the time has your **physical health** or **emotional problems** interfered with your social activities (like visiting with friends, relatives)?
 None of the time A little of the time Some of the time Most of the time All of the time

10. Please choose the answer that best describes **how true** or **false each** of the following statements is for you.

	Definitely true	Mostly true	Not sure	Mostly false	Definitely false
a. I seem to get sick a little easier than other people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I am as healthy as anybody I know	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I expect my health to get worse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. My health is excellent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

11. **Compared to 3 years ago**, how would you rate your **physical health** in general now?
 Much better Somewhat better About the same Somewhat worse Much worse

12. **Compared to 3 years ago**, how would you rate your **emotional health** or **well-being** (such as feeling anxious, depressed, or irritable) now?
 Much better Somewhat better About the same Somewhat worse Much worse

13. What is your **current** marital status? Choose the single best answer.

- Single, never married
- Now married
- Separated
- Divorced
- Widowed

14. (If not married) Please choose one of the following to describe your current relationship status:

- In a committed relationship
- Dating casually
- Not seeing anyone

15. (If currently married) Taking things all together, how would you describe your marriage?

- Very unhappy 1 2 3 4 5 6 7 Very happy
-

16. Including yourself, how many people currently reside in your household? (please do not include anyone that does not live and sleep in your household the majority of the time, such as visiting relatives)

--	--

 adults (18 and older)

--	--

 children (17 and younger, please include any biological, adopted, or foster children)

17. What is the **highest level** of education that you have **completed**? Choose the single best answer.

- Less than high school completion
- High school degree, GED, or equivalent
- Some college, no degree
- Associate's degree
- Bachelor's degree
- Master's, doctorate, or professional degree

18. Since 2001, have you taken any educational courses?

- No → [Skip to question 19](#)
- Yes, at an academic institution (non-military)
- Yes, at a military institution
- Yes, at a trade or technical school

a. Did you complete a degree/certificate as a result of these courses?

- No, didn't complete all the necessary coursework for a degree/certification
- No, coursework still in progress
- Yes → Year degree or certification completed

--	--	--	--

19. Which of the following **best** describes your employment status? Choose the single best answer.

- Full-time (greater than or equal to 30 hours per week)
- Part-time (less than 30 hours per week)
- Not employed, looking for work
- Not employed, not looking for work
- Not employed, retired
- Not employed, disabled
- Homemaker
- Other (please specify)

--

20. How tall are you? For example, a person who is 5'8" should write 5 feet 8 inches.....

	feet			inches
--	------	--	--	--------

21. What is your **current** weight?

			pounds
--	--	--	--------

22. How much did you weigh a **year ago**?

			pounds
--	--	--	--------

23. In the **last 3 years**, has your doctor or other health professional told you that you have any of the following conditions?

If **Yes**, in what year were you first diagnosed?

Mark here if you were hospitalized for the condition in the **last 3 years**.

a. Hypertension (high blood pressure)	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
b. High cholesterol requiring medication	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
c. Coronary heart disease	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
d. Heart attack	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
e. Angina (chest pain)	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
f. Any other heart condition (please specify) <input type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
g. Sinusitis	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
h. Chronic bronchitis	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
i. Emphysema	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
j. Asthma	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
k. Kidney failure requiring dialysis	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
l. Bladder infection	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
m. Pancreatitis	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
n. Diabetes or sugar diabetes	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
o. Gallstones	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
p. Kidney stones	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
q. Hepatitis B	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
r. Hepatitis C	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
s. Any other Hepatitis	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
t. Cirrhosis	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
u. Fibromyalgia	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
v. Rheumatoid Arthritis	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
w. Degenerative joint disease	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
x. Lupus	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized
y. Multiple Sclerosis	<input type="radio"/> No	<input type="radio"/> Yes	→	<input type="text"/>	→	<input type="radio"/> Hospitalized

Question 23 continued from the previous page

23. In the last 3 years, has your doctor or other health professional told you that you have any of the following conditions?			If Yes , in what year were you first diagnosed?	Mark here if you were hospitalized for the condition in the last 3 years .
z. Crohn's disease	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
aa. Stomach, duodenal, or peptic ulcer	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
bb. Ulcerative colitis or proctitis	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
cc. Acid reflux/ gastroesophageal reflux disease requiring medication	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
dd. Significant hearing loss	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
ee. Significant vision loss even with glasses or contact lenses	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
ff. Memory loss or memory impairment	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
gg. Tinnitus/ ringing in the ears	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
hh. Migraine headaches	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
ii. Stroke	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
jj. Traumatic brain injury (Do not include injuries that resulted in only a concussion)	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
kk. Neuropathy caused reduced sensation in the hands or feet	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
ll. Seizures	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
mm. Sleep apnea	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
nn. Anemia	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
oo. Thyroid condition other than cancer	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
pp. Cancer (please specify) <input style="width: 300px; height: 20px;" type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
qq. Chronic fatigue syndrome	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
rr. Depression	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
ss. Schizophrenia or psychosis	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
tt. Manic depressive disorder	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
uu. Posttraumatic stress disorder	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
vv. Infertility	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized
ww. Other (please specify) <input style="width: 300px; height: 20px;" type="text"/>	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	→ <input type="radio"/> Hospitalized

24. In the **last 3 years**, have you had persistent or recurring problems with any of the following?

a. Severe headache	<input type="radio"/> No <input type="radio"/> Yes	k. Night sweats	<input type="radio"/> No <input type="radio"/> Yes
b. Diarrhea	<input type="radio"/> No <input type="radio"/> Yes	l. Chest pain	<input type="radio"/> No <input type="radio"/> Yes
c. Rash or skin ulcer	<input type="radio"/> No <input type="radio"/> Yes	m. Unusual muscle pains	<input type="radio"/> No <input type="radio"/> Yes
d. Sore throat	<input type="radio"/> No <input type="radio"/> Yes	n. Shortness of breath	<input type="radio"/> No <input type="radio"/> Yes
e. Frequent bladder infections	<input type="radio"/> No <input type="radio"/> Yes	o. Trouble sleeping	<input type="radio"/> No <input type="radio"/> Yes
f. Cough	<input type="radio"/> No <input type="radio"/> Yes	p. Unusual fatigue	<input type="radio"/> No <input type="radio"/> Yes
g. Fever	<input type="radio"/> No <input type="radio"/> Yes	q. Forgetfulness	<input type="radio"/> No <input type="radio"/> Yes
h. Sudden unexplained hair loss ..	<input type="radio"/> No <input type="radio"/> Yes	r. Confusion	<input type="radio"/> No <input type="radio"/> Yes
i. Earlobe pain	<input type="radio"/> No <input type="radio"/> Yes	s. Other (please specify)	<input type="radio"/> No <input type="radio"/> Yes
j. Sleepy all the time.....	<input type="radio"/> No <input type="radio"/> Yes		

25. Over the **past 3 years**, have you had back pain, back aching, or back stiffness almost every day that lasted for 3 months or more in a row? No Yes

26. Over the **past 3 years**, approximately how many days were you hospitalized because of illness or injury? (exclude hospitalization for pregnancy and childbirth)

--	--	--

 days

27. Over the **past 3 years**, approximately how many days were you unable to work or perform your usual activities because of illness or injury? (exclude lost time for pregnancy and childbirth)

--	--	--

 days

28. During the **last 4 weeks**, how much have you been bothered by any of the following problems?

	Not bothered	Bothered a little	Bothered a lot
a. Stomach pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Back pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Pain in your arms, legs, or joints (knees, hips, etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Pain or problems during sexual intercourse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Chest pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Dizziness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Fainting spells	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Feeling your heart pound or race	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Shortness of breath	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Constipation, loose bowels, or diarrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Nausea, gas, or indigestion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Ringing in the ears	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. Difficulty with balance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. Women only: menstrual cramps or other problems with your periods	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

29. Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Trouble falling or staying asleep, or sleeping too much	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Feeling tired or having little energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Poor appetite or overeating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. 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"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Moving or speaking so slowly that other people could have noticed, or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. If you answered "several days" or more to any item above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? <input type="radio"/> Not at all difficult <input type="radio"/> Somewhat difficult <input type="radio"/> Very difficult <input type="radio"/> Extremely difficult				

30. a. In the **last 4 weeks**, have you had an anxiety attack - suddenly feeling fear or panic? No Yes

If you marked NO, please skip to question 32

- b. Has this ever happened to you before? No Yes
- c. Do some of these attacks come **suddenly out of the blue** - that is, in situations where you don't expect to be nervous or uncomfortable? No Yes
- d. Do these attacks bother you a lot, or are you worried about having another attack? No Yes

31. Think about your last bad anxiety attack.

- a. Were you short of breath? No Yes
- b. Did your heart race, pound, or skip? No Yes
- c. Did you have chest pain or pressure? No Yes
- d. Did you sweat? No Yes
- e. Did you feel as if you were choking? No Yes
- f. Did you have hot flashes or chills? No Yes
- g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea? No Yes
- h. Did you feel dizzy, unsteady, or faint? No Yes
- i. Did you have tingling or numbness in parts of your body? No Yes
- j. Did you tremble or shake? No Yes
- k. Were you afraid you were dying? No Yes

32. Over the **last 4 weeks**, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days
a. Feeling nervous, anxious, on edge, or worrying a lot about different things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you marked NOT AT ALL, please skip to question 33

b. Feeling restless so that it is hard to sit still	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Getting tired very easily	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Muscle tension, aches, or soreness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Trouble falling asleep or staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Trouble concentrating on things, such as reading a book or watching TV ..	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Becoming easily annoyed or irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

33. On an **average day**, how many 8-12 oz beverages containing caffeine do you drink (such as coffee, tea, soda)?

- None 1-2 per day 3-5 per day 6-10 per day 11 or more per day

34. About how many times **each week** do you eat from a fast food restaurant (such as hamburgers, tacos, or pizza)?

- None Once a week 2-3 times/week 4-7 times/week 8-14 times/week 15 or more times/week

35. a. Do you often feel that you can't control **what** or **how much** you eat?

- No Yes

b. Do you often eat, **within any 2 hour period**, what most people would regard as an unusually **large** amount of food?

- No Yes

c. If you marked **YES** to either of the above, has this been as often, on average, as **twice a week** for the **LAST 3 MONTHS**?

- No Yes

36. In the last 3 years, have you and a partner tried to get pregnant?

- No Yes Not applicable

If you marked NO or NOT APPLICABLE, skip to question 38

37. **If YES**, in the last 3 years, have you and a partner been unsuccessful getting pregnant for **a year or more** (not including time spent apart, such as deployment)?

- No Yes

38. In the last 3 years, if you and a partner got pregnant, did you have a miscarriage?

Does not apply (no pregnancy)

No miscarriage

Yes, 1 miscarriage → year

--	--	--	--

Yes, 2 miscarriages → years

--	--	--	--

--	--	--	--

Yes, 3 miscarriages → years

--	--	--	--

--	--	--	--

--	--	--	--

40. **FOR WOMEN ONLY:**

	No	Yes	Does not apply
a. Are you currently pregnant?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Have you given birth within the last 3 years ?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. In the last 3 years , have you been diagnosed with gestational diabetes by a glucose tolerance test during pregnancy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

41. During the **last 4 weeks**, how much have you been bothered by any of the following problems?

	Not bothered	Bothered a little	Bothered a lot
a. Worrying about your health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Your weight or how you look	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Little of no sexual desire or pleasure during sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Difficulties with husband/wife, partner/lover, or boyfriend/girlfriend	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. The stress of taking care of children, parents, or other family members	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Stress at work outside of the home or at school	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Financial problems or worries	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Having no one to turn to when you have a problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Something bad that happened recently	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Thinking or dreaming about something terrible that happened to you in the past -like your house being destroyed, a severe accident, being hit or assaulted, or being forced into a sexual act	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

42. Please indicate the degree to which the following statements describe your feelings and behavior.

	Not at all	1	2	3	4	5	6	7	Exactly so
	0								8
a. I often find myself getting angry at people or situations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. When I get angry, I get really mad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. When I get angry, I stay angry	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. When I get angry at someone, I want to hit or clobber the person	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. My anger prevents me from getting along with people as well as I'd like to	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

43. How often in the past month did you get angry with someone and kick/smash something, get into a fight or hit someone, or threaten someone with physical violence?

- Never 1 time 2 times 3-4 times 5 or more times

44. Are you **currently** taking any medicine for anxiety, depression, or stress? No Yes

45. In the last 12 months, did you use prescription-strength pain relievers (including any narcotics or medications such as Codeine, OxyContin, Percocet)?

- Never Once a month Few days per month Few days per week Daily

46. Over the **past month**, how many hours of sleep did you get in an average 24-hour period?

--	--

 hours

47. Please rate your sleep pattern for the **past 2 weeks**.

	None	Mild	Moderate	Severe	Very severe
a. Difficulty falling asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Difficulty staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Problem waking up too early	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Snoring	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

48. How **satisfied**/dissatisfied are you with your current sleep pattern?

- Very satisfied Generally satisfied Somewhat dissatisfied Very dissatisfied

49. To what extent do you consider your sleep pattern to **interfere** with your daily functioning (such as daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)?

- Not at all interfering A little Somewhat Much Very much interfering

50. How **noticeable** to others do you think your sleeping pattern is in terms of impairing the quality of your life?

- Not at all noticeable Barely Somewhat Much Very much noticeable

51. How **worried**/distressed are you about your current sleep pattern?

- Not at all A little Somewhat Much Very much

52. During the **past month**, how often have you taken medicine (prescribed or "over the counter") to help you sleep?

- Not at all during past month Less than once a week Once or twice a week Three or more times a week

53. Do you consider yourself to be:

- Heterosexual or straight Gay or lesbian Bisexual

54. People are different in their sexual attraction to other people. Which best describes your feelings? Are you:

- Only attracted to females Mostly attracted to males
 Mostly attracted to females Only attracted to males
 Equally attracted to females and males Not sure

55. Choose the single best description of your **USUAL** daily activities

- You sit during the day and do not walk much
 You stand or walk a lot during the day, but do not carry or lift things often
 You lift or carry light loads, or climb stairs or hills often
 You do heavy work or carry heavy loads often

56. In a **typical week**, how much time do you spend participating in...
 (Please mark both your typical "days per week" and "minutes per day" doing these activities)

	# of days per week you exercise		On those days, how many minutes per day on average do you exercise	
a. STRENGTH TRAINING or work that strengthens your muscles? (such as lifting/pushing/pulling weights)	<input type="text"/> days	AND	<input type="text"/> <input type="text"/> <input type="text"/> minutes	OR <input type="radio"/> None <input type="radio"/> Cannot physically do
b. VIGOROUS exercise or work that causes heavy sweating or large increases in breathing or heart rate? (such as running, active sports, marching, biking)	<input type="text"/> days	AND	<input type="text"/> <input type="text"/> <input type="text"/> minutes	OR <input type="radio"/> None <input type="radio"/> Cannot physically do
c. MODERATE or LIGHT exercise or work that causes light sweating or slight increases in breathing or heart rate? (such as walking, cleaning, slow jogging)	<input type="text"/> days	AND	<input type="text"/> <input type="text"/> <input type="text"/> minutes	OR <input type="radio"/> None <input type="radio"/> Cannot physically do

57. In the **past month** have you experienced...?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
a. Repeated, disturbing memories of stressful experiences from the past	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Repeated, disturbing dreams of stressful experiences from the past	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Suddenly acting or feeling as if stressful experiences were happening again	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Feeling very upset when something happened that reminds you of stressful experiences from the past	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Trouble remembering important parts of stressful experiences from the past	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Loss of interest in activities that you used to enjoy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Feeling distant or cut off from other people	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Feeling emotionally numb, or being unable to have loving feelings for those close to you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Feeling as if your future will somehow be cut short	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Trouble falling asleep or staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Feeling irritable or having angry outbursts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Difficulty concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Feeling "super-alert" or watchful or on guard	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. Feeling jumpy or easily startled	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. Physical reactions when something reminds you of stressful experiences from the past	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
p. Efforts to avoid thinking about your stressful experiences from the past or avoid having feelings about them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
q. Efforts to avoid activities or situations because they remind you of stressful experiences from the past	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
r. Thinking about all items in question 57 a-q above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? <input type="radio"/> Not at all difficult <input type="radio"/> Somewhat difficult <input type="radio"/> Very difficult <input type="radio"/> Extremely difficult					
s. Thinking about all items in question 57 a-q above, did these problems cause you to feel distress? <input type="radio"/> Not at all <input type="radio"/> A little bit <input type="radio"/> Moderately <input type="radio"/> Quite a bit <input type="radio"/> Extremely					

58. On a **typical day**, how much time do you spend sitting and watching TV or videos or using a computer?

--	--

 hours per day

59. From the following list, indicate if you have used each health practice in the last 12 months.

- | | |
|---|--|
| <p>a. Acupuncture <input type="radio"/> No <input type="radio"/> Yes</p> <p>b. Biofeedback <input type="radio"/> No <input type="radio"/> Yes</p> <p>c. Chiropractic care <input type="radio"/> No <input type="radio"/> Yes</p> <p>d. Energy healing <input type="radio"/> No <input type="radio"/> Yes</p> <p>e. Folk remedies <input type="radio"/> No <input type="radio"/> Yes</p> <p>f. Herbal therapy <input type="radio"/> No <input type="radio"/> Yes</p> <p>g. Yoga <input type="radio"/> No <input type="radio"/> Yes</p> <p>h. Movement therapy <input type="radio"/> No <input type="radio"/> Yes</p> | <p>i. High dose / megavitamin therapy <input type="radio"/> No <input type="radio"/> Yes</p> <p>j. Homeopathy <input type="radio"/> No <input type="radio"/> Yes</p> <p>k. Hypnosis <input type="radio"/> No <input type="radio"/> Yes</p> <p>l. Massage <input type="radio"/> No <input type="radio"/> Yes</p> <p>m. Relaxation <input type="radio"/> No <input type="radio"/> Yes</p> <p>n. Spiritual healing <input type="radio"/> No <input type="radio"/> Yes</p> <p>o. Meditation <input type="radio"/> No <input type="radio"/> Yes</p> <p>p. Breathing techniques <input type="radio"/> No <input type="radio"/> Yes</p> |
|---|--|

60. If you answered "Yes", to any item in question 59 above, has your level of satisfaction with conventional medicine led you to seek alternative health practices? No Yes

61. Have you taken any of the following supplements in the **last 12 months**?

- | | | |
|--|--------------------------|---------------------------|
| a. Body building supplements (such as amino acids, weight gain products, creatine, etc.) | <input type="radio"/> No | <input type="radio"/> Yes |
| b. Energy supplements (such as energy drinks, pills, or energy enhancing herbs) | <input type="radio"/> No | <input type="radio"/> Yes |
| c. Weight loss supplements | <input type="radio"/> No | <input type="radio"/> Yes |
| d. Hormones for muscular strength, enhancement, or performance | <input type="radio"/> No | <input type="radio"/> Yes |

62. In the **last 4 weeks**, how much have your family or friends supported you?

- Not at all A little bit Moderately Quite a bit Extremely

63. Indicate the degree to which the following statements are true in your life...

		To a very small degree	To a small degree	To a moderate degree	To a great degree	To a very great degree
a. I prioritize what is important in life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I have an appreciation for the value of my own life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I am able to do good things with my life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. I have an understanding of spiritual matters	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. I have a sense of closeness with others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. I have established a path for my life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. I know that I can handle difficulties	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. I have religious faith	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. I'm stronger than I thought I was	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. I have learned a great deal about how wonderful people are	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. I have compassion for others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

64. Please indicate your level of agreement with these statements:

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
a. I have little control over the things that happen to me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. What happens to me in the future mostly depends on me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I can do just about anything I really set my mind to do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

65. In the last 12 months, did you seek care for any of the following concerns?

a. Posttraumatic stress disorder (PTSD) or posttraumatic stress (PTS) symptoms	<input type="radio"/> No	<input type="radio"/> Yes
b. Depression	<input type="radio"/> No	<input type="radio"/> Yes
c. Anxiety	<input type="radio"/> No	<input type="radio"/> Yes
d. Substance use	<input type="radio"/> No	<input type="radio"/> Yes
e. Anger	<input type="radio"/> No	<input type="radio"/> Yes
f. Stress	<input type="radio"/> No	<input type="radio"/> Yes
g. Relationship/family issues	<input type="radio"/> No	<input type="radio"/> Yes

66. a. If you answered "Yes" to any of the items in question 65 above, how many times did you seek these services in the last 12 months?

- Once a year A few times a year Once a month Several times a month Weekly

b. Where did you receive care for these services? (check all that apply)

- Military resource/provider VA resource/provider Civilian resource/provider

67. In the last 12 months, have you had a physical health concern for which you considered seeking medical care?

- No → skip to question 68 Yes

a. (If YES) When you had these physical health concerns, how often did you seek care?

- None of the time A little of the time Some of the time Most of the time All of the time

b. **If you did NOT seek care "All of the time"**, what were the reasons you did NOT seek care? (check all that apply)

- | | |
|--|--|
| <input type="radio"/> The problem wasn't bad enough to get help | <input type="radio"/> I don't trust health professionals |
| <input type="radio"/> I preferred to manage the problem on my own | <input type="radio"/> I don't think health care treatment would help |
| <input type="radio"/> Fear of negative effects on military career | <input type="radio"/> Treatment might be uncomfortable or difficult |
| <input type="radio"/> Concern that others would think negatively of me | <input type="radio"/> Cannot afford treatment/no health insurance |

68. a. Have you found it necessary to sleep in a shelter, on the streets, or in another non-residential setting because of having no other place to stay? (Please only refer to instances during or after military service time) No Yes

b. **If YES**, please indicate the dates of your most recent situation:

m	m	y	y		m	m	y	y
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

to

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

These next few questions are about drinking alcoholic beverages. Alcoholic beverages include beer, wine, and liquor (such as whiskey, gin, etc.). For the purpose of this questionnaire:

One drink = one 12-ounce beer, one 4-ounce glass of wine, or one 1.5-ounce shot of liquor

69. In the **past year**, how **often** did you typically drink any type of alcoholic beverage?

- Never Rarely Monthly Weekly Daily

If you marked NEVER, skip to question 79 on page 15

70. In the **past year**, on those days that you drank alcoholic beverages, on average, how many drinks did you have?

--	--

 drinks

71. In a **typical week**, how many drinks of each type of alcoholic beverage do you have? (If NONE, please enter 0)

--	--	--	--	--	--	--	--	--	--	--	--

 beer(s) wine liquor

72. **Last week**, how many drinks of alcoholic beverages did you have? (If NONE, please enter 0)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

73. In the **past year**, on how many **days** did you have 5 or more drinks of any alcoholic beverage? (If NONE, please enter 0) days

--	--	--

74. In the **past year**, how **often** did you typically get drunk (intoxicated)?

- Never Monthly or less 2-4 times a month >4 times per month

75. **FOR MEN ONLY:**

In the **past year**, how often did you typically have **5** or more drinks of alcoholic beverages within a **2- hour period**?

- Never Monthly or less 2-4 times a month >4 times per month

76. **FOR WOMEN ONLY:**

In the **past year**, how often did you typically have **4** or more drinks of alcoholic beverages within a **2- hour period**?

- Never Monthly or less 2-4 times a month >4 times per month

77. In the **last 12 months**, have any of the following happened to you **more than once**?

- a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health No Yes
- b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities No Yes
- c. You missed or were late for work, school, or other activities because you were drinking or hung over No Yes
- d. You had a problem getting along with people while you were drinking No Yes
- e. You drove a car after having several drinks or after drinking too much No Yes

78. Have you **ever** felt any of the following?

- a. Felt you needed to cut back on your drinking No Yes
- b. Felt annoyed at anyone who suggested you cut back on your drinking No Yes
- c. Felt you needed an "eye-opener" or early morning drink No Yes
- d. Felt guilty about your drinking No Yes

79. In the **past year**, have you used any of the following tobacco products?

- a. Cigarettes No Yes
- b. Cigars No Yes
- c. Pipes No Yes
- d. Smokeless tobacco (chew, dip, snuff) No Yes

80. In your **lifetime**, have you smoked at least 100 cigarettes (5 packs)? No Yes

If you marked NO, skip to question 85

81. At what age did you start smoking? years old

82. How many years have or did you smoke an average of at least 3 cigarettes per day (or one pack per week)? years

83. When smoking, how many packs per day did you or do you smoke?
 Less than half a pack a day Half to 1 pack per day 1 to 2 packs per day More than 2 packs per day

84. Have you ever tried to quit smoking?
 Yes, and succeeded Yes, but not successfully No

85. In the past 3 years , have any of the following life events happened to you?	No	Yes	If YES , list most recent year
a. You moved or changed residence more than once	<input type="radio"/>	<input type="radio"/> →	
b. You changed job, assignment, or career path involuntarily (for example, you lost a job, or you had to take a job you did not like)	<input type="radio"/>	<input type="radio"/> →	
c. You or your partner had an unplanned pregnancy	<input type="radio"/>	<input type="radio"/> →	
d. You were divorced or separated	<input type="radio"/>	<input type="radio"/> →	
e. Suffered major financial problems (such as bankruptcy)	<input type="radio"/>	<input type="radio"/> →	
f. Suffered forced sexual relations or sexual assault	<input type="radio"/>	<input type="radio"/> →	
g. Experienced sexual harassment	<input type="radio"/>	<input type="radio"/> →	
h. Suffered a violent assault	<input type="radio"/>	<input type="radio"/> →	
i. Had a family member or loved one who became severely ill	<input type="radio"/>	<input type="radio"/> →	
j. Had a family member or loved one who died	<input type="radio"/>	<input type="radio"/> →	
k. Suffered a disabling illness or injury	<input type="radio"/>	<input type="radio"/> →	

86. During the **past 3 years**, have you been **PERSONALLY** exposed to any of the following?
 (Do not include TV, video, movies, computers, or theater)

	No	Yes, 1 time	Yes, more than 1 time	If YES , list most recent year of exposure
a. Witnessing a person's death due to war, disaster, or tragic event ..	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	2 0
b. Witnessing instances of physical abuse (torture, beating, rape)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	2 0
c. Dead and/or decomposing bodies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	2 0
d. Maimed soldiers or civilians	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	2 0
e. Prisoners of war or refugees	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	2 0
f. Chemical or biological warfare agents	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	2 0
g. Medical countermeasures for chemical or biological warfare agent exposure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	2 0
h. Alarms necessitating wearing of chemical or biological warfare protective gear	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	2 0

It would be helpful for this study to know about the background experiences that may have happened to some people.

- 87 a. Before the age of 18, how often did a parent or other adult in your home ever hit, beat, kick, or physically hurt you in any way?
 Never Once More than once Prefer not to answer
- b. Before the age of 18, how often did a parent or other adult in your home ever touch your private parts when they shouldn't have or make you touch their private parts? Or did a parent or other adult that took care of you force you to have sex?
 Never Once More than once Prefer not to answer
- c. Before the age of 18, how often did you get scared or feel really bad because a parent or other adult in your home called you names, said mean things to you or said that they didn't want you?
 Never Once More than once Prefer not to answer
- d. When someone is neglected, it means that the grown-ups in their life didn't take care of them the way that they should. They might not get enough food, take them to the doctor when they are sick, or make sure they have a safe place to stay. At any time before the age of 18, were you neglected?
 Never Once More than once Prefer not to answer

88. During the **past 3 years**, were you **PERSONALLY** exposed to any of the following?

	No	Don't know	Yes	If YES , list most recent year of exposure
a. Occupational hazards requiring protective equipment, such as respirators or hearing protection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	2 0
b. Routine skin contact with paint and/or solvent and/or substances	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	2 0
c. Depleted uranium (DU)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	2 0
d. Microwaves (excluding small microwave ovens)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	2 0
e. Pesticides, including creams, sprays, or uniform treatments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	2 0
f. Pesticides applied in the environment or around living facilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> →	2 0

89. What is your current military status?

Active duty → skip to question 94

Separated → skip to question 90

Reserve or National Guard → skip to question 92

Retired → skip to question 90

90. a. What was your date of separation/retirement from the military:

mm / yy
[] [] / [] []

b. What was the reason for your separation/retirement from the military?

Planned separation
(end of service term/retirement)

Unplanned administrative separation
(e.g. military downsizing, failure to promote,
failure to meet service standards)

Medical separation

Disciplinary separation

Other
(e.g. pregnancy, parenthood, educational
pursuits)

91. How much did each of the following reasons affect your decision to leave the military?

Not at all A little bit Moderately Quite a bit Extremely

	Not at all	A little bit	Moderately	Quite a bit	Extremely
a. Dissatisfaction with deployments and/or frequent moves	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Military service created hardship for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Dissatisfaction with promotion, pay, or other benefits	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Dissatisfaction with job	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Dissatisfaction with leadership/supervision	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Desire to continue your education, start a new career, or change in personal goals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Disability or other medical reasons	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Difficulty meeting weight standards and/or fitness standards	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Incompatibility with the military	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Legal problems or problems meeting a military obligation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Fulfilled term of service or was retirement eligible	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

92. Has the VA determined that you have one or more service connected disabilities? No Yes

a. If **YES**, indicate the total percent of your VA service-connected disabilities. [] [] [] percent disability

93. In the last 3 years, have you received any medical care from Department of Veterans Affairs/Veterans Health Administration facilities?

None Very little Some Most All of my care

94. What kind of health coverage or insurance do you currently have? (check all that apply)

No health coverage or insurance

Medicare

School health insurance plan

Medicaid

TRICARE or military health insurance plan

VA health care

Employer health insurance plan

(Department of Veterans Affairs/
Veterans Health Administration)

(self, spouse/partner, parent, or other family member)

95. Have you deployed in the last 3 years? No → skip to question 100 Yes

96. If YES and on a SEA-based deployment, list the **specific** SEA-based area along with the dates you arrived and departed from each location. Please list the most recent location first.

Please list specific location here		Date arrived		Date departed					
		m	m	y	y	m	m	y	y
a.	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>
b.	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>
c.	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>
d.	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>

97. If YES and on a LAND-based deployment, list the **specific** countries along with the dates you arrived and departed from each location. Please list the most recent location first.

Please list specific location here		Date arrived		Date departed					
		m	m	y	y	m	m	y	y
a.	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>
b.	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>
c.	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>
d.	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	/	<input type="text"/>

98. In the **last 3 years**, how often have you experienced the following during deployment?

	Never	1 time	More than 1 time	→	List most recent year of exposure
a. Feeling that you were in great danger of being killed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	→	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>
b. Being attacked or ambushed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	→	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>
c. Receiving small arms fire	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	→	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>
d. Clearing / searching homes or buildings	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	→	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>
e. Having an improvised explosive device (IED) or booby trap explode near you	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	→	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>
f. Being wounded or injured	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	→	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>
g. Seeing dead bodies or human remains	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	→	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>
h. Handling or uncovering human remains	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	→	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>
i. Knowing someone seriously injured or killed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	→	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>
j. Seeing Americans who were seriously injured or killed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	→	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>
k. Having a member of your unit be seriously injured or killed ...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	→	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>
l. Being directly responsible for the death of an enemy combatant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	→	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>
m. Being directly responsible for the death of a non-combatant	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	→	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>
n. Being exposed to smoke from burning trash and/or feces	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	→	<input type="text"/> 2 <input type="text"/> 0 <input type="text"/> <input type="text"/>

99. Within the **last 3 years**, were you injured **while deployed** from any of the following? If you experienced more than 1 injury during deployment, please provide responses for the most severe injury.

a. **Physical training or sports injury while deployed**

No → [skip to 99b](#) Yes

a1. Did this injury involve being dazed, confused, "seeing stars," or not remembering the injury?

No Yes, 0-30 minutes Yes, more than 30 minutes

a2. Did this injury involve losing consciousness (such as getting knocked out)?

No Yes, 0-30 minutes Yes, more than 30 minutes

a3. Were you ever hospitalized or did this injury disrupt your personal and/or work activities for more than 1 day?

No Yes

b. **Blast/Explosion while deployed**

No → [skip to 99c](#) Yes

b1. Did this injury involve being dazed, confused, "seeing stars," or not remembering the injury?

No Yes, 0-30 minutes Yes, more than 30 minutes

b2. Did this injury involve losing consciousness (such as getting knocked out)?

No Yes, 0-30 minutes Yes, more than 30 minutes

b3. Were you ever hospitalized or did this injury disrupt your personal and/or work activities for more than 1 day?

No Yes

c. **Bullet/Shrapnel while deployed**

No → [skip to 99d](#) Yes

c1. Did this injury involve being dazed, confused, "seeing stars," or not remembering the injury?

No Yes, 0-30 minutes Yes, more than 30 minutes

c2. Did this injury involve losing consciousness (such as getting knocked out)?

No Yes, 0-30 minutes Yes, more than 30 minutes

c3. Were you ever hospitalized or did this injury disrupt your personal and/or work activities for more than 1 day?

No Yes

d. **Motor vehicle accident/crash while deployed**

No → [skip to 100](#) Yes

d1. Did this injury involve being dazed, confused, "seeing stars," or not remembering the injury?

No Yes, 0-30 minutes Yes, more than 30 minutes

d2. Did this injury involve losing consciousness (such as getting knocked out)?

No Yes, 0-30 minutes Yes, more than 30 minutes

d3. Were you ever hospitalized or did this injury disrupt your personal and/or work activities for more than 1 day?

No Yes

100. Within the **last 3 years**, were you injured **while NOT** deployed from any of the following? If you experienced more than 1 injury while not deployed, please provide responses for the most severe injury.

a. **Physical training or sports injury while NOT deployed**

Yes No

a1. Did this injury involve being dazed, confused, "seeing stars," or not remembering the injury?

No Yes, 0-30 minutes Yes, more than 30 minutes

a2. Did this injury involve losing consciousness (such as getting knocked out)?

No Yes, 0-30 minutes Yes, more than 30 minutes

a3. Were you ever hospitalized or did this injury disrupt your personal and/or work activities for more than 1 day?

No Yes

b. **Blast/Explosion while NOT deployed**

Yes No

b1. Did this injury involve being dazed, confused, "seeing stars," or not remembering the injury?

No Yes, 0-30 minutes Yes, more than 30 minutes

b2. Did this injury involve losing consciousness (such as getting knocked out)?

No Yes, 0-30 minutes Yes, more than 30 minutes

b3. Were you ever hospitalized or did this injury disrupt your personal and/or work activities for more than 1 day?

No Yes

c. **Bullet/Shrapnel while NOT deployed**

Yes No

c1. Did this injury involve being dazed, confused, "seeing stars," or not remembering the injury?

No Yes, 0-30 minutes Yes, more than 30 minutes

c2. Did this injury involve losing consciousness (such as getting knocked out)?

No Yes, 0-30 minutes Yes, more than 30 minutes

c3. Were you ever hospitalized or did this injury disrupt your personal and/or work activities for more than 1 day?

No Yes

d. **Motor vehicle accident/crash while NOT deployed**

Yes No

d1. Did this injury involve being dazed, confused, "seeing stars," or not remembering the injury?

No Yes, 0-30 minutes Yes, more than 30 minutes

d2. Did this injury involve losing consciousness (such as getting knocked out)?

No Yes, 0-30 minutes Yes, more than 30 minutes

d3. Were you ever hospitalized or did this injury disrupt your personal and/or work activities for more than 1 day?

No Yes

101. Within the last 3 years, have you been in a motor vehicle accident / crash while NOT deployed? No Yes

If NO, skip to question 102

a. How many motor vehicle accident / crash events in the last 3 years?

- 1 2 3 or more events

b. List the dates of the 3 most recent motor vehicle accident(s) / crash(s), and indicate which one of these was the most severe event.

 m m y y
 □ □ / □ □ → Most severe event

 □ □ / □ □ → Most severe event

 □ □ / □ □ → Most severe event

c. For the most SEVERE motor vehicle accident/crash:

c1. What type of vehicle were you in?

- Motorcycle Personal car/truck Government vehicle

c2. How many vehicles were involved?

- Your vehicle only Multiple vehicles

c3. What was your role?

- Driver Passenger

c4. Which of the following factors (related to the DRIVER) were involved in the motor vehicle accident / crash?

- Speed No Yes
Alcohol No Yes
Fatigue/drowsiness No Yes
Distraction (e.g. cell phone) No Yes
Strong emotions (e.g. road rage) No Yes

d. What is the total number of work days lost as a result of the motor vehicle accident / crash: days

e. What treatment did you seek for your injuries from this motor vehicle accident / crash?
 No treatment sought Clinic or office visit only Hospitalized: number of days: days

102. What is your annual **household** income?
- less than \$25,000
 - \$25,000-\$49,999
 - \$50,000-\$74,999
 - \$75,000-\$99,999
 - \$100,000-\$124,999
 - \$125,000-\$149,999
 - \$150,000 or more

103. What is your overall feeling about your military service?
- Negative
 - Somewhat negative
 - Neither negative nor positive
 - Somewhat positive
 - Positive

The statements below are about your relationships with other military personnel.

104. If you had deployed in the last 3 years, please indicate how much you agree or disagree for each item, based on your most recent deployment. If you have not deployed in the last 3 years, please indicate how much you agree or disagree for each item based on your most recent assignment.

		Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree
a. I felt a sense of camaraderie between myself and others in my unit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. I was impressed by the quality of leadership in my unit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. I was supported by the military	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

We really appreciate your answers to the questions on the survey. Please continue on to the last few questions on the next 5 pages about your military occupational categories and contact information.

105. If you are **ENLISTED** (Active Duty, Reserve, or National Guard), please review the list of military occupational categories below. Select the **two** categories that **best match** your military job and fill in the two-digit codes for your **primary** job code and your **secondary** job code. [All others, skip to question 106 on page 24.](#)

PRIMARY JOB CODE SECONDARY JOB CODE

ENLISTED MILITARY OCCUPATIONAL CATEGORIES

INFANTRY, GUN CREWS & SEAMANSHIP SPECIALISTS

Infantry.....	01
Armor or Amphibious.....	02
Combat Engineering.....	03
Artillery/Gunnery, Rockets or Missiles.....	04
Air Crew.....	05
Seamanship.....	06
Installation Security.....	07

ELECTRONIC EQUIPMENT REPAIRERS

Radio/Radar.....	10
Fire Control Electric Systems, Non-Missile.....	11
Missile Guidance, Control or Check-out.....	12
Sonar Equipment.....	13
Nuclear Weapons Equipment.....	14
ADP Computers.....	15
Teletype or Cryptographic Equipment.....	16
Other Electronic Equipment.....	19

COMMUNICATIONS & INTELLIGENCE SPECIALISTS

Radio or Radio Code.....	20
Sonar.....	21
Radar or Air Traffic Control.....	22
Signal Intel/Electronic Warfare.....	23
Intelligence.....	24
Combat Operations Control.....	25
Communications Center Operations.....	26

HEALTH CARE SPECIALISTS

Medical Care.....	30
Ancillary Medical Support.....	31
Biomedical Sciences or Allied Health.....	32
Dental Care.....	33
Medical Administration or Logistics.....	34

OTHER TECHNICAL AND ALLIED SPECIALISTS

Photography.....	40
Mapping, Surveying, Drafting or Illustrating.....	41
Weather.....	42
Ordnance Disposal or Diving.....	43
Musician.....	45
Technical Specialist.....	49

FUNCTIONAL SUPPORT & ADMINISTRATION

Personnel.....	50
Administration.....	51
Clerical/Personnel.....	52
Data Processing.....	53
Accounting, Finance or Disbursing.....	54
Other Functional Support.....	55
Religious, Morale or Welfare.....	56
Information or Education.....	57

ELECTRICAL/MECHANICAL EQUIPMENT REPAIRERS

Aircraft or Aircraft Related.....	60
Automotive.....	61
Wire Communications.....	62
Missile Mechanical or Electrical.....	63
Armament or Munitions.....	64
Shipboard Propulsion.....	65
Power Generating Equipment.....	66
Precision Equipment.....	67
Other Mechanical or Electrical Equipment.....	69

CRAFTWORKERS

Metalworking.....	70
Construction.....	71
Utilities.....	72
Lithography.....	74
Industrial Gas or Fuel Production.....	75
Fabric, Leather or Rubber.....	76
Other Craftworker.....	79

SERVICE & SUPPLY HANDLERS

Food Service.....	80
Motor Transport.....	81
Material Receipt, Storage or Issue.....	82
Law Enforcement.....	83
Personnel Service.....	84
Auxiliary Labor.....	85
Forward Area Equipment Support.....	86
Other Services.....	87

OTHER

Patients or Prisoners.....	90
Officer Candidate or Student.....	91
Undesignated Occupations.....	92
Not Occupationally Qualified.....	95

106. If you are an **OFFICER** or **WARRANT OFFICER** (Active Duty, Reserve, or National Guard), please review the list of military occupational categories below. Select the **two** categories that **best match** your military job and fill in the two-digit codes for your **primary** job code and your **secondary** job code. [All others, skip to question 107](#) on page 25.

PRIMARY JOB CODE

SECONDARY JOB CODE

OFFICER or WARRANT OFFICER MILITARY OCCUPATIONAL CATEGORIES

TACTICAL OPERATIONS OFFICERS

Fixed-Wing Fighter or Bomber Pilot..... 2A
 Helicopter Pilot..... 2C
 Aircraft Crew..... 2D
 Ground or Naval Arms..... 2E
 Missiles..... 2F
 Operations Staff..... 2G
 Civilian Pilot..... 2H

INTELLIGENCE OFFICERS

Intelligence, General..... 3A
 Communications Intelligence..... 3B
 Counter-intelligence..... 3C

ENGINEERING & MAINTENANCE OFFICERS

Construction or Utilities..... 4A
 Ordnance..... 4B
 Communications or Radar..... 4C
 Aviation Maintenance or Allied..... 4D
 Electrical or Electronic..... 4E
 Missile Maintenance..... 4F
 Ship Construction or Maintenance..... 4G
 Ship Machinery..... 4H
 Safety..... 4J
 Chemical..... 4K
 Automotive or Allied..... 4L
 Surveying or Mapping..... 4M
 Other..... 4N

SCIENTISTS & PROFESSIONALS

Physical Scientist..... 5A
 Meteorologist..... 5B
 Biological Scientist..... 5C
 Social Scientist..... 5D
 Psychologist..... 5E
 Legal..... 5F
 Chaplain..... 5G
 Social Worker..... 5H
 Mathematician or Statistician..... 5J
 Educator or Instructor..... 5K
 Research & Development Coordinator..... 5L
 Community Activities Officer..... 5M
 Scientist or Professional..... 5N

GENERAL OFFICERS & EXECUTIVES

General or Flag..... 1A
 Executive..... 1B

HEALTH CARE OFFICERS

Physician..... 6A
 Dentist..... 6C
 Nurse..... 6E
 Veterinarian..... 6G
 Biomedical Sciences or Allied Health..... 6H
 Health Service Administration..... 6I

ADMINISTRATORS

Administrator, General..... 7A
 Training Administrator..... 7B
 Manpower or Personnel..... 7C
 Comptroller or Fiscal..... 7D
 Data Processing..... 7E
 Pictorial..... 7F
 Information..... 7G
 Police..... 7H
 Inspection..... 7L
 Morale & Welfare..... 7N

SUPPLY, PROCUREMENT & ALLIED OFFICERS

Logistics, General..... 8A
 Supply..... 8B
 Transportation..... 8C
 Procurement or Production..... 8D
 Food Service..... 8E
 Exchange or Commissary..... 8F
 Other..... 8G

OTHER

Patient..... 9A
 Student..... 9B
 Other..... 9E

107. If you have a **CIVILIAN** job, please review the list of **civilian** occupational categories on this page and the next page. Select the **two** categories that **best match** your civilian job and fill in the three-digit codes for your **primary** and your **secondary** job code.

PRIMARY JOB CODE

SECONDARY JOB CODE

CIVILIAN OCCUPATIONAL CATEGORIES

More categories listed on page 26

ARCHITECTURE & ENGINEERING

Architect, Surveyor or Cartographer 171
 Engineer..... 172
 Drafter, Engineering or Mapping Technician..... 173

ARTS, DESIGN, MEDIA, ENTERTAINMENT & SPORTS

Art or Design..... 271
 Entertainer, Performer, Sports or Related Worker..... 272
 Media Communication Worker..... 273
 Media Communication Equipment Worker..... 274

BUILDING & GROUNDS CLEANING & MAINTENANCE

Supervisor, Building & Grounds, Cleaning & Maintenance Worker..... 371
 Building Cleaning or Pest Control..... 372
 Ground Maintenance..... 373

BUSINESS & FINANCIAL OPERATIONS

Business Operations Specialist..... 131
 Financial Specialist..... 132

COMMUNITY & SOCIAL SERVICES

Counselor, Social Worker or Other Community or Social Service Specialist..... 211
 Religious Worker..... 212

COMPUTER & MATHEMATICAL

Computer Specialist 151
 Mathematical Specialist..... 152
 Mathematical Technician..... 153

CONSTRUCTION & EXTRACTION

Supervisor, Construction or Extraction Worker..... 471
 Construction Trades Worker..... 472
 Helper, Construction Trades..... 473
 Other Construction or Related Worker..... 474
 Extraction Worker..... 475

EDUCATION, TRAINING & LIBRARY

Postsecondary Teacher..... 251
 Primary, Secondary or Special Education School Teacher..... 252
 Other Teacher or Instructor..... 253
 Librarian, Curator or Archivist..... 254
 Other Education, Training or Library Occupation..... 259

FARMING, FISHING & FORESTRY WORKERS

Supervisor, Farming, Fishing or Forestry Worker..... 451
 Agricultural Worker..... 452
 Fishing or Hunting Worker..... 453
 Forest, Conservation or Logging Worker..... 454
 Other Farming, Fishing or Forestry..... 459

FOOD PREPARATION & SERVING RELATED

Supervisor, Food Preparation or Serving..... 351
 Cook or Food Preparation Worker..... 352
 Food and Beverage Worker..... 353
 Other Food Preparation or Serving Related Worker..... 359

HEALTH CARE

Physician..... 295
 Nursing, Psychiatric or Home Health Aid..... 311
 Occupational or Physical Therapist Assistant or Aid..... 312
 Other Health Care Occupation..... 319

INSTALLATION, REPAIR & MAINTENANCE

Supervisor of Installation, Maintenance or Repair Worker..... 491
 Electrical or Electric Equipment Mechanic, Installer or Repairer..... 492
 Vehicle or Mobile Equipment Mechanic, Installer or Repairer..... 493
 Other Installation, Maintenance or Repair..... 499

More categories listed on page 26...

CIVILIAN OCCUPATIONAL CATEGORIES

LEGAL

Lawyer, Judge or Related Worker.....	231
Legal Support Worker.....	232

LIFE, PHYSICAL & SOCIAL SCIENCES

Life Scientist.....	191
Physical Scientist.....	192
Social Scientist or Related Worker.....	193
Life, Physical or Social Sciences Technician.....	194

MANAGEMENT

Top Executive.....	111
Advertising, Marketing, Promotions, PR or Sales Manager.....	112
Operations Specialties Manager.....	113
Other Management Occupation.....	119

OFFICE & ADMINISTRATIVE SUPPORT

Supervisor, Office or Administrative Support.....	431
Communications Equipment Operator.....	432
Financial Clerk.....	433
Information or Record Clerk.....	434
Material Recording, Scheduling, Dispatching or Distributing Worker.....	435
Secretary or Administrative Assistant.....	436
Other Office or Administrative Support.....	439

PERSONAL CARE SERVICE

Supervisor, Personal Care or Service.....	391
Animal Care or Service.....	392
Entertainment Attendant or Related Worker.....	393
Funeral Worker.....	394
Personal Appearance.....	395
Transportation, Tourism or Lodging Attendant.....	396
Other Personal Care or Service Worker.....	399

PRODUCTION

Supervisor, Production Worker.....	511
Assembler, Fabricator.....	512
Food Processing Worker.....	513
Metal or Plastic Worker.....	514
Printing Worker.....	515
Textile, Apparel or Furnishing Worker.....	516
Woodworker.....	517
Plant or Systems Operator.....	518
Other Production Occupation.....	519

PROTECTIVE SERVICES

First Line Supervisor/Manager, Protective Services.....	331
Firefighting or Prevention Worker.....	332
Law Enforcement Worker.....	333
Other Protective Service Worker.....	339

SALES-RELATED

Supervisor, Sales.....	411
Retail Sales Worker.....	412
Sales Representative, Services.....	413
Sales Representative, Wholesale or Manufacturing.....	414
Counter or Rental Clerk or Parts Salesperson.....	415
Other Sales or Related Worker.....	419

TRANSPORTATION & MATERIAL MOVING

Supervisor, Transportation or Material Moving.....	531
Motor Vehicle Operator.....	533
Rail Transportation Worker.....	534
Water Transportation.....	535
Other Transportation.....	536
Material Moving Worker.....	537

