Survey number: _____-____

OMB CONTROL NUMBER: XXXX-XXXX
OMB EXPIRATION DATE: XX/XX/XXXX

AGENCY DISCLOSURE NOTICE

The public reporting burden for this collection of information, 0702-XXXX, is estimated to average 60 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 the burden estimate or burden reduction suggestions to the Department of Defense, Washington Headquarters Services, at whs.mc-alex.esd.mbx.dd-dod-information-collections@mail.mil. 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.

PLEASE DO NOT RETURN YOUR RESPONSE TO THE ABOVE ADDRESS.

Responses should be sent to US Army Public Health Center, ATTN: Dr. Coleen Baird, 5158 Blackhawk Road, Aberdeen Proving Ground, Maryland 21010-5403.

Post Deployment Health Survey

You may also complete this questionnaire online at htpps://aphc.secure.survey.mil

Instructions

- Use BLUE or BLACK ink.
- Shade circles like this: ●
- Cross out mistakes with an "X".

This question is modeled from question 15 of the Milco Survey □ Print in CAPITAL LETTERS.

- Avoid contact with the edge of the box, like this:

H	E	L	L	O

M M / D D / Y Y Y Y

1. What is today's date? | | | | | | | | |
2. **Has your doctor or other health professional ever told you that you have any of the following conditions?**

		No	Yes		If YES, in what year were you **first** diagnosed?				Mark here if you were ever hospitalized for the condition
a. Hypertension									
b. High cholesterol (requiring medication)									
c. Coronary heart disease									
d. Heart attack									
e. Angina (chest pain)									
f. Any other heart condition (please specify)									
g. Sinusitis									
h. Chronic bronchitis									
i. Emphysema									
j. Asthma									
k. Kidney failure requiring dialysis									
l. Bladder infection									
m. Pancreatitis									
n. Diabetes or sugar diabetes									
o. Gallstones									
p. Kidney stones									
q. Hepatitis B									
r. Hepatitis C									
s. Any other hepatitis									
t. Cirrhosis									
u. Fibromyalgia									
v. Rheumatoid arthritis									
w. Lupus									
x. Multiple									

sclerosis									
y. Crohn's diseae									
z. Stomach, duodenal, or peptic ulcer									
aa. Ulcerative colitis or proctitis									
bb. Acid reflux / gastroesophageal reflux disease requiring medication									
cc. Significant hearing loss									
dd. Significant vision loss even with glasses or contact lenses									
ee. Tinnitus / ringing of the ears									
ff. Migraine headaches									
gg. Stroke									
hh. Neuropathy-caused reduced sensation in hands or feet									
ii. Seizures									
jj. Sleep apnea									
kk. Anemia									
ll. Thyroid condition other than cancer									
mm. Cancer Please specify:									
nn. Chronic fatigue syndrome									
oo. Depression									
pp. Schizophrenia or psychosis									
qq. Manic-									

depressive disorder									
rr. Posttraumatic stress disorder									
ss. Infertility									
tt. Other Please specify:									

3. **During the last 12 months, have you had persistent or recurring problems with any of the following?**

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