

SUPPLEMENTAL HEALTH SCREENING QUESTIONNAIRE

(For use of this form, see USMEPCOM Regulation 40-1)

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PRIVACY ACT STATEMENT

Authority: Title 10, United States Code (USC), Sections 504, 505, 507, 532, 978, 1201, 1202, and 4346; Executive Orders 9397 and 13478 (SSN)

Principal purpose: To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.

Routine uses: None. The Department of Defense "Blanket Routine Uses" set forth at the beginning of the Army's compilations of system of records notices applies to this system.

Disclosure: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

| | | | | | | | | |
|---|--|----------------|----------------------------------|---------------|--|---|--|--|
| 1. Last Name - First Name - Middle Name (Suffix) | | | 2. Social Security Number | | | 3. Date of Birth (YYYYMMDD) | | |
| 4. Date of Exam (YYYYMMDD) | | 5. MEPS | | 6. Sex | | 7a. Service <input type="checkbox"/> ARMY <input type="checkbox"/> AIR FORCE <input type="checkbox"/> MARINE CORPS <input type="checkbox"/> NAVY <input type="checkbox"/> COAST GUARD | | |
| | | | | | | 7b. Component <input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> NATIONAL GUARD <input type="checkbox"/> RESERVE | | |

8. Screening Questions Part 1 - Place a mark (X) in the column that corresponds to your answer to each of the following questions. All "YES" answers must be fully explained on page 2 of this form. Note: An answer is required for every question.

| YES | NO | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | a. Were you ever depressed or down, most of the day, nearly every day for 2 weeks? |
| <input type="checkbox"/> | <input type="checkbox"/> | b. For the past 2 weeks , were you depressed or down, most of the day, nearly every day? |
| <input type="checkbox"/> | <input type="checkbox"/> | c. Were you ever much less interested in most things or much less able to enjoy the things you used to enjoy most of the time, for 2 weeks? |
| <input type="checkbox"/> | <input type="checkbox"/> | d. In the past 2 weeks , were you much less interested in most things or much less able to enjoy the things you used to enjoy, most of the the time? |
| <input type="checkbox"/> | <input type="checkbox"/> | e. Have you ever deliberately cut, burned, or injured yourself? |
| <input type="checkbox"/> | <input type="checkbox"/> | f. Have you ever considered or attempted suicide? |
| <input type="checkbox"/> | <input type="checkbox"/> | g. Have you ever been arrested? |
| <input type="checkbox"/> | <input type="checkbox"/> | h. Have you ever been suspended from school? |
| <input type="checkbox"/> | <input type="checkbox"/> | i. Have you ever been fired from your job? |
| <input type="checkbox"/> | <input type="checkbox"/> | j. Have you ever been kicked out of your home? |
| <input type="checkbox"/> | <input type="checkbox"/> | k. Have you had three or more traffic violations? |
| <input type="checkbox"/> | <input type="checkbox"/> | l. Have you ever had trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning waking or sleeping excessively) for a period of 2 weeks or longer? |

9. Screening Questions Part 2 - Place a mark (X) in the box that corresponds to your answer to each of the following questions.

| | |
|--|--|
| a. How often do you have a drink containing alcohol? <input type="checkbox"/> Never <input type="checkbox"/> Monthly or less <input type="checkbox"/> Two to four times a month <input type="checkbox"/> Two or three times per week <input type="checkbox"/> Four or more times a week | |
| b. How many drinks containing alcohol do you have on a typical day? <input type="checkbox"/> Never <input type="checkbox"/> 1 or 2 <input type="checkbox"/> 3 to 6 <input type="checkbox"/> 7 to 9 <input type="checkbox"/> 10 or more | |
| c. How often do you have six or more drinks on one occasion? <input type="checkbox"/> Never <input type="checkbox"/> Less than monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Two or three times per week <input type="checkbox"/> Four or more times a week | |

I certify that all the information provided on this form is complete and true to the best of my knowledge.

| | |
|-----------------------------------|-----------------------------------|
| 10. Signature of Applicant | 11. Date Signed (YYYYMMDD) |
|-----------------------------------|-----------------------------------|

12. Last Name - First Name - Middle Name (Suffix)

13. Social Security Number

14. Comments. Note item by number (8a-8l) and provide an explanation of any "YES" answer.