Naval Medicine Readiness and Training Detachment Bridgeport
DeWert Branch Clinic
Building 3005, State Route 108
Bridgeport, CA 93517

Clinic Hours: Monday to Friday (0800 – 1600)
Phone: (760) 932-1616

Separation/Retirement Physicals

Within 180 days of last active-duty day

Step 1: Schedule first appointment with Medical Readiness staff to receive packet and medical readiness review to identify additional requirements per orders. Fill out **highlighted portions** indicated and obtain dental signature.

- **DD Form 2807-1 -** Explain all "Yes" answers in block 29 (expect 14c) with dates, given treatment and current medical status.
  - Ex: 12c. Low back pain (2011-2021). On and off pain, no medical care sought out, self-manageable. No limitations and able to complete PFT/CFT without medical waiver.
- **DD Form 2808**
  - Page 1, Block 43 – **DENTAL** completes and signs Page 3, Block 84a-b.
  - Page 2, Blocks 60- 70 – **OPTOMETRY** completes. In clinic Snellen if 20/20; optometry if not.
  - Page 2, Block 71a-72c – **AUDIOLOGY** completes. Must be within 6 months of separation.
- **3 Question TBI Screening Tool**
- **PCL-5**
- **SF 600, MANMED Chapter 15, Separation from Active Duty**
- **NPPSC 1900/1, Separations Questionnaire (Navy) -** Medical and Dental Endorsement

Step 2: Return **COMPLETED** packet to Medical Readiness for staff verification.

Step 3: Once packet is verified complete, to include all medical readiness requirements, an **IN-PERSON** appointment will be scheduled with a medical officer.

Additional Medical Screenings (If indicated)

☐ Lipids (40 years or older)
☐ Hemoglobin A1C (40 years old and BMI greater than 25)
☐ Lung cancer screening (55 years or older with history of smoking)
☐ Colonoscopy (50 years or older)
☐ Syphilis (If high risk)
☐ Pap smear
☐ Mammogram (Every 2 years for 40 years and older)

STAFF NOTES
DD Form 2808: HIV, Audiometric test, visual acuity, dental, Pap smear.

REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

OMB No. 0704-0413
OMB approval expires 20241031

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 136, Under Secretary of Defense For Personnel and Readiness; DoD Directive 1145.2, United States Military Entrance Processing Command; DoD Instruction 6130.03, Medical Standards for Appointment, Enlistment, or Induction in the Military Services; and E.O. 9397 (SSN), as amended.
PRINCIPAL PURPOSE(S): The primary collection of this information is from individuals seeking to join the Armed Forces. The information collected on this form is used to assist DoD physicians in making determinations as to acceptability of applicants for military service and verifies disqualifying medical condition(s) noted on the prescreening from (DD 2807-2)/. An additional collection of information using this form occurs when a Medical Evaluation Board is convened to determine the medical fitness of a current member and if separation is warranted.
ROUTINE USE(S): The Routine Uses are listed in the applicable system of records notice found at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/
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. An applicant's SSN is used during t he recruitment process to keep all records together and when requesting civilian medical records. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status. The SSN of an Armed Forces member is to ensure the collected information is filed in the proper individual's record.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2.a SOCIAL SECURITY NO.	b. DoD ID NO. *(If applicable)*	3. TODAY'S DATE *(YYYYMMDD)*

4.a. HOME ADDRESS *(Stress, Apartment No., City, State, and ZIP Code)*	5. EXAMINING LOCATION AND ADDRESS *(Include Zip Code)*
b. HOME TELEPHONE *(Include Area Code)*	NMRTD BRIDGEPORT DEWERT BRNACH CLINIC BUILDING 3005, STATE ROUTE 108 BRIDGEPORT, CA 93517
c. EMAIL ADDRESS	

X ALL APPLICABLE BOXES:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION
☐ Army ☐ Navy ☐ Marine Corps ☐ Air Force ☐ Coast Guard	☐ Regular ☐ Reserve ☐ National Guard	☐ Retention ☐ Separation ☐ Medical Board ☐ Retirement ☐ Other *(Specify)*

7.a. POSITION *(Title, Grade, Component)*

b. USUAL OCCUPATION

8. CURRENT MEDICATIONS *(Prescription and Over-the-Counter)*

9. ALLERGIES *(Including insect bites/stings, foods, medicine, or other substance)*

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
10.a. Tuberculosis	○	○
b. Lived with someone who had tuberculosis	○	○
c. Coughed up blood	○	○
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	○
e. Shortness of breath	○	○
f. Bronchitis	○	○
g. Wheezing or problems with wheezing	○	○
h. Been prescribed or used an inhaler	○	○
i. A chronic cough or cough at night	○	○
j. Sinusitis	○	○
k. Hay fever	○	○
l. Chronic or frequent colds	○	○
11.a. Severe tooth or gum trouble	○	○
b. Thyroid trouble or goiter	○	○
c. Eye disorder or trouble	○	○
d. Ear, nose, or throat trouble	○	○
e. Loss or vision in either eye	○	○
f. Worn contact lenses or glasses	○	○
g. A hearing loss or wear a hearing aid	○	○
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	○	○
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	○	○
b. Arthritis, rheumatism, or bursitis	○	○
c. Recurrent back pain or any back problem	○	○
d. Numbness or tingling	○	○
e. Loss of finger or toe	○	○

12. *(Continued)*	YES	NO
f. Foot trouble *(e.g., pain, corns, bunions, etc.)*	○	○
g. Impaired use of arms, legs, hands, or feet)	○	○
h. Swollen or painful joint(s)	○	○
i. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)*	○	○
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts, or orthotics, etc.	○	○
l. Bone, joint, or other deformity	○	○
m. Plate(s), screw(s), rod(s), or pin(s) in any bone	○	○
n. Broken bone(s) *(cracked of fractured)*	○	○
13.a. Frequent indigestion or heartburn	○	○
b. Stomach, liver, intestinal trouble, or ulcer	○	○
c. Gall bladder trouble or gallstones	○	○
d. Jaundice or hepatitis *(liver disease)*	○	○
e. Rupture/hernia	○	○
f. Rectal disease, hemorrhoids, or blood from the rectum	○	○
g. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)*	○	○
h. Frequent or painful urination	○	○
i. High or low blood sugar	○	○
j. Kidney stone or blood in urine	○	○
k. Sugar or protein in urine	○	○
l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)*	○	○
14.a. Adverse reaction to serum, food, insect stings, or medicine	○	○
b. Recent unexplained gain or loss of weight	○	○
c. Currently in good health *(If no, explain in Item 29 on Page 2.)*	○	○
d. Tumor, growth, cyst, or cancer	○	○

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER *(If applicable)*

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
15.a. Dizziness or fainting spells	○	○
b. Frequent or severe headache	○	○
c. A head injury, memory loss or amnesia	○	○
d. Paralysis	○	○
e. Seizures, convulsions,epilepsy, or fits	○	○
f. Car, train,sea,or air sickness	○	○
g. A period of unconsciousness or concussion	○	○
h. Meningitis, encephalitis, or other neurological problems	○	○
16.a. Rheumatic fever	○	○
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	○	○
c. Pain or pressure in the chest	○	○
d. Palpitation, pounding heart or abnormal heartbeat	○	○
e. Heart trouble or murmur	○	○
f. High or low blood pressure	○	○
17.a. Nervous trouble of any sort *(anxiety or panic attacks)*	○	○
b. Habitual stammering or stuttering	○	○
c. Loss of memory or amnesia, or neurological symptoms	○	○
d. Frequent trouble sleeping	○	○
e. Received counseling of any type	○	○
f. Depression or excessive worry	○	○
g. Been evaluated or treated for a mental condition	○	○
h. Attempted suicide	○	○
i. Used illegal drugs or abused prescription drugs	○	○
18. **FEMALES ONLY.** Have you ever had or do you now have:	○	○
a. Treatment for a gynecological (female) disorder	○	○
b. A change of menstrual pattern	○	○
c. Any abnormal PAP smears	○	○
d. First day of last menstrual period *(YYYYMMDD)*		
e. Date of last PAP smear *(YYYYMMDD)*		

	YES	NO
19. Have you been refused employment, or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○
b. Inability to perform certain motions	○	○
c. Inability to stand, sit, kneel, lie down, etc.	○	○
d. Other medical reasons *(If yes, give reasons.)*	○	○
20. Have you ever been treated in an Emergency Room? *(If yes, for what?)*	○	○
21. Have you ever been a patient in any type of hospital? *(If yes, specify when, where,why, and name of doctor and complete address of hospital.*	○	○
22. Have you ever had, or have you been advised to have any operations or surgery? *(If yes, describe and give age at which occurred.)*	○	○
23. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*	○	○
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor,* hospital*, clinic, and details.)*	○	○
25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)*	○	○
26. Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*	○	○
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? *(If yes, specify what kind, granted by whom, and what amount, when , why.)*	○	○
28. Have you ever been denied life insurance?	○	○

29. EXPLANATION OF "YES" ANSWER(S) *(Describe answer(s), give date(s) of problem, name of doctor(s)and/or* **hospital***(s), treatment given and current medical status.)*

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY.'

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER	DoD ID NUMBER *(If applicable)*

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2a. SOCIAL SECURITY NUMBER	2b. DoD ID NUMBER (If applicable)

PRIVACY ACT STATEMENT

AUTHORITY: 10 U.S.C. 504, Persons not qualified; 10 U.S.C. 505, **Regular components: qualifications, term, grade;** 10 U.S.C. 507**, Extension of enlistment for members needing medical care or hospitalization;** 10 U.S.C. 532, Qualifications for original appointment as a commissioned officer; 10 U.S.C. 978, Drug and alcohol abuse and dependency: testing of new entrants; 10 U.S.C. 1201, Regulars and members on active duty for more than 30 days: retirement; 10 U.S.C. 1202, Regulars and members on active duty for more than 30 days: temporary disability retired list; 10 U.S.C. 4346, Cadets: requirements for admission; DoD Directive 1145.2, United States Military Entrance Processing Command; E.O. 9397 (SSN) and 10 U.S.C. 1204, Members on Active Duty for 30 Days or Less or on Inactive Duty Training: Retirement, as amended.
PRINCIPAL PURPOSE(S): 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 USE(S): The Routine Uses are listed in the applicable system of records notice found at: http://dpcld.defense.gov/Privacy/SORNsIndex/DOD-wide-SORN-Article-View/Article/570661/a0601-270-usmepcom-dod/
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.

3. LAST NAME - FIRST NAME - MIDDLE NAME (Suffix)	4. HOME ADDRESS (Street, Apartment Number, City, State and Zip Code)	5a. HOME TELEPHONE NUMBER (Include Area Code)	5b. E-MAIL ADDRESS

6. GRADE/ RANK	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX	10. RACE AND ETHNICITY (Select All That Apply)
			☐ Male ☐ Female	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other

11. TOTAL YEARS GOVERNMENT SERVICE		12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE
a. MILITARY	b. CIVILIAN		

14a. RATING OR SPECIALTY (Aviators Only)	14b. TOTAL FLYING TIME	14c. LAST SIX MONTHS

15a. SERVICE	15b. COMPONENT	15c. PURPOSE OF EXAMINATION	
☐ Army	☐ Active Duty	☐ Enlistment	☐ Retirement
☐ Air Force	☐ Reserve	☐ Commission	☐ U.S. Service Academy
☐ Marine Corps	☐ National Guard	☐ Retention	☐ ROTC Scholarship Program
☐ Navy		☐ Separation	☐ Medical Board
☐ Coast Guard		☐ Other _____	
☐ USPHS			

16. NAME OF EXAMINING LOCATION, AND ADDRESS *(Include Zip Code)*

NMRTD BRIDGEPORT
DEWERT BRNACH CLINIC
BUILDING 3005, STATE ROUTE 108
BRIDGEPORT, CA 93517

MEDICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Normal	Abnormal	NE
17. Head, face, neck and scalp	☐	☐	☐
18. Nose	☐	☐	☐
19. Sinuses	☐	☐	☐
20. Mouth and throat	☐	☐	☐
21. Ears - General *(Int. and ext. canals/Auditory acuity under item 71)*	☐	☐	☐
22. Tympanic Membranes *(Perforation)*	☐	☐	☐
23. Eyes - General	☐	☐	☐
24. Ophthalmoscopic	☐	☐	☐
25. Pupils *(Equality and reaction)*	☐	☐	☐
26. Ocular motility *(Associated parallel movements, nystagmus)*	☐	☐	☐
27. Heart *(Thrust, size, rhythm, sounds)*	☐	☐	☐
28. Lungs and chest *(Include breasts)*	☐	☐	☐
29. Vascular system *(Varicosities, etc.)*	☐	☐	☐
30. Anus and rectum *(Hemorrhoids, Fistulae) (Prostate if indicated)*	☐	☐	☐
31. Abdomen and viscera *(Include hernia)*	☐	☐	☐
32. External genitalia *(Genitourinary)*	☐	☐	☐
33. Upper extremities	☐	☐	☐
34. Lower extremities *(Except feet)*	☐	☐	☐
35. Feet *(Check category)*	☐	☐	☐
35a. ☐ Normal Arch ☐ Pes Planus ☐ Pes Cavus			
35b. ☐ Mild ☐ Moderate ☐ Severe			
35c. ☐ Asymptomatic ☐ Symptomatic ☐ Rigid			
36. Spine, other musculoskeletal	☐	☐	☐
37. Body marks, scars, tattoos	☐	☐	☐
38. Skin, lymphatics	☐	☐	☐
39. Neurologic	☐	☐	☐
40. Psychiatric *(Specify any personality disorder)*	☐	☐	☐
41. Pelvic *(Females only)*	☐	☐	☐
42. Endocrine	☐	☐	☐

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist. If abnormality noted, explain in item 44.)*

Acceptable ☐
Not Acceptable ☐
Class _____

44. NOTES: *(Mandatory comment for every abnormality identified in items 17 - 43. Enter pertinent item number before each comment. Continue comments or use drawings in item 89 and use additional sheets if necessary.)*

LAST NAME - FIRST NAME - MIDDLE NAME *(Suffix)*	SOCIAL SECURITY NUMBER	DoD ID NUMBER

LABORATORY FINDINGS

45. URINALYSIS	a. Albumin	b. Sugar	46. URINE HCG	47. H/H	48. BLOOD TYPE

TESTS	RESULTS	HIV SPECIMEN ID LABEL	DRUG TEST SPECIMEN ID LABEL
49. HIV			
50. DRUGS			
51. ALCOHOL			
52. OTHER			
a. PAP SMEAR			
b. EKG			
c. CXR			

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT *(in.)*	54. WEIGHT *(lbs.)*	55a. MIN WGT	55b. MAX WGT	55c. MAX BF %	55d. BMI	56. TEMPERATURE	57. HEART RATE

58. BLOOD PRESSURE			59. RED/GREEN	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD		
SYS.	SYS.	SYS.		
DIAS.	DIAS.	DIAS.		

61. DISTANCE VISION		62. REFRACTION ☐ AUTO ☐ MANIFEST ☐ CYCLO			63. NEAR VISION		
Right Uncorr. 20/	Corr. to 20/	Sph:	Cyl:	Axis:	Right Uncorr. 20/	Corr. to 20/	Add:
Left Uncorr. 20/	Corr. to 20/	Sph:	Cyl:	Axis:	Left Uncorr. 20/	Corr. to 20/	Add:

64. HETEROPHORIA							
ES	EX	R.H.	L.H.	Prism div.	Prism Conv CT	NPR	PD

65. ACCOMMODATION		66. COLOR VISION *(Pass/Fail and Score)*			67. DEPTH PERCEPTION *(Pass/Fail and Score)*	
Right	Left	PIP	RED/ GREEN	Color Dx	AFVT	RANDOT/ MCST

68. FIELD OF VISION	69. NIGHT VISION	70. INTRAOCULAR PRESSURE	
		O.D.	O.S.

71a. AUDIOMETER Unit Serial Number	71b. Unit Serial Number	72a. READING ALOUD TEST: ☐ SAT ☐ UNSAT
Date Calibrated *(YYYYMMDD)*	Date Calibrated *(YYYYMMDD)*	72b. VALSALVA: ☐ SAT ☐ UNSAT

HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000
Left							Left						
Right							Right						

72c. OTHER TESTING

73. NOTES AND/OR INTERVAL HISTORY

LAST NAME - FIRST NAME - MIDDLE NAME *(Suffix)*	SOCIAL SECURITY NUMBER	DoD ID NUMBER

74. EXAMINEE	75. I have been advised of my disqualifying condition(s).
☐ IS MEDICALLY QUALIFIED ☐ IS NOT MEDICALLY QUALIFIED	**75a. SIGNATURE OF EXAMINEE** / **75b. DATE** *(YYYYMMDD)*

76. PHYSICAL PROFILE

P	U	L	H	E	S	X	D	PROFILER INITIALS	DATE *(YYYYMMDD)*

77. SIGNIFICANT OR DISQUALIFYING MEDICAL DIAGNOSES

ITEM NO.	MEDICAL DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE *(YYYYMMDD)*	QUALIFIED	DISQUALIFIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE *(YYYYMMDD)*

78. SUMMARY OF MEDICAL DIAGNOSES *(List diagnoses with item numbers) (Use additional sheets if necessary).*

79. RECOMMENDATIONS *(Specify) (Use additional sheets if necessary).*

80. MEPS WORKLOAD *(For MEPS use only)*

WKID	ST	DATE *(YYYYMMDD)*	INITIALS	WKID	ST	DATE *(YYYYMMDD)*	INITIALS

81. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	EXAMINER'S NAME AND SIGNATURE

82a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	82b. Signature
83a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	83b. Signature
84a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	84b. Signature
85a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY *(Indicate which)*	85b. Signature

86. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE	b. GRADE	c. DATE *(YYYYMMDD)*

87. WAIVER GRANTED *(If yes, date and by whom)*	YES ☐	NO ☐	88. NUMBER OF ATTACHED SHEETS

89. ADDITIONAL REMARKS

3 Question TBI Screening Tool

1. Did you have any injury(ies) during your deployment(s) or garrison/training from any of the following during your time in service - OR - did you have any injury(ies) from any of the following not service related? (check all that apply):

A. □ Fragment
B. □ Bullet
C. □ Vehicular (any type of vehicle, including airplane)
D. □ Fall
E. □ Blast (Improvised Explosive Device, RPG, Land mine, Grenade, etc.)
F. □ Other specify: _____

2. Did any injury received while you were deployed or in garrison/training - OR - any injury received not service related, result in any of the following? (check all that apply):

A. □ Being dazed, confused or “seeing stars”
B. □ Not remembering the injury
C. □ Losing consciousness (knocked out) for less than a minute
D. □ Losing consciousness for 1-20 minutes
E. □ Losing consciousness for longer than 20 minutes

F. □ Having any symptoms of concussion afterward
(such as headache, dizziness, irritability, etc.)
G. □ Head Injury

H. □ None of the above

3. Are you currently experiencing any of the following problems that you think might be related to a possible head injury or concussion? (check all that apply):

A. □ Headaches
B. □ Dizziness
C. □ Memory problems
D. □ Balance problems
E. □ Ringing in the ears
F. □ Irritability
G. □ Sleep problems
H. □ Other specify:_____

Patient name: _____ Date: _____

PCL-5

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving *actual or threatened death, serious injury, or sexual violence*. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a *serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.*

First, please answer a few questions about your *worst event*, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so): _____

How long ago did it happen? _____ ***(please estimate if you are not sure)***

Did it involve actual or threatened death, serious injury, or sexual violence?

_____Yes

_____No

How did you experience it?

_____ It happened to me directly

_____ I witnessed it

_____ I learned about it happening to a close family member or close friend

_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)

_____ Other, please describe _____

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

_____Accident or violence

_____Natural causes

_____Not applicable (the event did not involve the death of a close family member or close friend)

Second, keeping this worst event in mind, read each of the problems on the next page and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	*Not at all*	*A little bit*	*Moderately*	*Quite a bit*	*Extremely*
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again *(as if you were actually back there reliving it)*?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience *(for example, heart pounding, trouble breathing, sweating)*?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience *(for example, people, places, conversations, activities, objects, or situations)*?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world *(for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)*?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings *(for example, being unable to feel happiness or have loving feelings for people close to you)*?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being “superalert” or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Adult Medical Care Clinic, MCAGCC Naval Hospital 29 Palms, CA 92278-8250

MANMED, Chapter 15 (12 AUG 2005)

SEPARATION FROM ACTIVE DUTY, BUMEDNOTE 6230 (Dec, 2005)

You have been evaluated because of your planned separation or retirement from active duty service. You have been found physically qualified to separate or retire, which means that no medical condition has been noted that disqualifies you from the performance of your duties or warrants disability evaluation system processing. To receive disability benefits from the Department of the Navy, you must be unfit to perform the duties of your office, grade, or rating because of a disease or injury incurred or exacerbated while in receipt of base pay. Some conditions, while not considered disqualifying for separation or retirement, may entitle you to benefits from the Department of Veteran's Affairs. If you desire additional information regarding these benefits, contact the Department of Veteran's Affairs at 1-800-827-1000 or view the Web site at: http://www.va.gov.

Patient Signature: _____ Date:_____

Member's Medical History has been reviewed and interval changes since last Exam include:

Focused Exam (if needed):

Additional items that need to be updated:

Member IS / IS NOT Physically Qualified for Separation/Retirement.

Examining Provider Signature & Stamp:_____ Date:_____

NAME:

SSN:

RANK:

DOB:

Revised SF-600

June 25, 2019