



DEPARTMENT OF HOMELAND SECURITY  
**DHS Post Deployment Health Screening Questionnaire**

**INSTRUCTIONS:** This document addresses deployment related exposures that you may have come in-contact with during your tour of duty. Every work experience is unique and may reflect individual differences regarding exposures. Completion of this document is voluntary. If you do not wish to participate, you are required to complete the attached Declination Form.

1. Complete each item based on your personal experience during your deployment and your best judgment of actual or suspected exposures. Additional hazards may be noted and commented upon in the spaces provided.
2. Sign the Authorization for Release of Information and return it along with this survey to your component medical reviewing physician or agency equivalent.

**Today's Date** \_\_\_\_\_

LAST NAME \_\_\_\_\_ FIRST (No nicknames) \_\_\_\_\_ MIDDLE \_\_\_\_\_

Sex:  Male  Female Age: \_\_\_\_\_ Job Title: \_\_\_\_\_

Component \_\_\_\_\_ DISTRICT/DIVISION ADDRESSES \_\_\_\_\_ YOUR WORK TELEPHONE NO. \_\_\_\_\_

|   |
|---|
| <p><b>Deployment Dates: From:</b> _____ <b>To:</b> _____</p> <p><b>What were your duties during deployment?</b> (Please check that apply applies)</p> <p><input type="checkbox"/> Search, Rescue      <input type="checkbox"/> Law Enforcement/Security</p> <p><input type="checkbox"/> Safety/Health      <input type="checkbox"/> Recovery</p> <p><input type="checkbox"/> Immigration Enforcement duties</p> <p><input type="checkbox"/> Operations      <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Peer Support/Critical Incident Stress Management      <input type="checkbox"/> Medical/Health Care</p> |
| <p><b>Worksite</b> (Please check each check boxes that applies):</p> <p><input type="checkbox"/> Deployment sites: _____ Daily travel time to work site (if applicable): _____</p> <p><input type="checkbox"/> hrs/day    <input type="checkbox"/> days/week    <input type="checkbox"/> weeks/month    _____ total months</p> <p><b>Shift Work: (check one):</b> _____ 8 hours    _____ 12 hours    _____ 16 hours    _____ other(explain): _____</p> <p>Total Hours per week (worked): _____</p> <p><b>Rest Periods:</b></p> <p>Average hours sleep per day/night: _____</p> <p>Was sleep/rest period uninterrupted? _____</p>        |



**Housing**

How were you housed while deployed?

Fixed Shelter     
  Tents     
  Mobile Unit     
  Open Air/On the Ground  
 Other: \_\_\_\_\_

**Did your temporary house include (Check all that apply)?**  
 Heating  
 Ventilation  
 Adequate lighting  
 Toilet facilities  
 Shower facilities

**Food/Nutrition:**

Did you have adequate supplies of (potable) drinking water?  
 Yes  
 No

Were food storage containers clearly marked and segregated to the extent possible to prevent contamination?  
 Yes  
 No. If No, please explain: \_\_\_\_\_

If applicable, were food preparation surfaces cleaned and disinfected regularly?  
 Yes  
 No  
 Not Applicable

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**Personal Protective Equipment (PPE) Used at Recovery Site** (Please check each checkboxes that applies):

Respirator (please print type e.g., disposable mask, half face reusable, full face, PAPR, SCBA).  
 \_\_\_\_\_

Gloves     
 Coveralls (Cloth and/or disposable)     
 Insect repellent     
 Steel toed construction shoes

Goggles / Glasses     
 Hearing Protection (check: Muffs / Ear Plugs)  
 Hard hat

Other \_\_\_\_\_

If you were required to wear a respirator, did you receive a medical evaluation prior to wearing the respirator?  
 Yes  
 No

If you were required to wear a respirator, were you fit-tested on same type of respirator?  
 Yes  
 No

**Exposures:** The following questions pertain only to your deployment

1. Did you require medical attention during your deployment?  
 Yes  
 No  
 If "Yes", please explain  
 \_\_\_\_\_
2. Did you work in close proximity to flood waters?  
 Yes  
 No  
 If "Yes", How many hours (average) \_\_\_\_\_  
 and how many days? \_\_\_\_\_
3. Did you sustain any skin wounds?  
 Yes  
 No  
 If "Yes", please describe:  
 \_\_\_\_\_
4. Did you experience any bites (Insects, snakes, dogs, other)  
 Yes  
 No  
 If "Yes", please describe:  
 \_\_\_\_\_
5. Did you experience any type of injury or trauma to your head, neck, torso or limbs?  
 Yes  
 No  
 If "Yes", please describe:  
 \_\_\_\_\_



6. Did you handle or manipulate deceased persons?  Yes  No  
 If yes, what type of personal protective equipment (PPE) did you wear? \_\_\_\_\_
7. Do you have concerns about possible exposures or events during this deployment that you feel may affect your health?  
 Yes  No If Yes, please explain: \_\_\_\_\_

**EXPOSURE TABLE** - The potential exposures listed below refer to your deployment.

| EXPOSURE TYPE   | LENGTH OF EXPOSURE                    | PROTECTION USED WITH EXPOSURE  | Comments  |
|---|---------------------------------------|--|---|
| <b>INSTRUCTIONS</b><br>Check chemicals or work conditions that apply to you | <b>INSTRUCTIONS</b><br>Number of days | <b>INSTRUCTIONS</b><br>% Time you wore protective equipment with this exposure (i.e., 10%, 25%, 50%, etc.) | <b>Please include any additional comments you may wish to add.</b><br>(Write legibly) |
| Dust  |                                       |  |   |
| Fumes   |                                       |  |   |
| Gases   |                                       |  |   |
| Carbon Monoxide   |                                       |  |   |
| Cement Dust   |                                       |  |   |
| Other Dust  |                                       |  |   |
| Chemicals/Solvents (Specify if known)                                       |                                       |  |   |
| Blood/Body Fluids   |                                       |  |   |
| Sewage (Untreated)  |                                       |  |   |
| Smoke/Fire  |                                       |  |   |
| Other Exposure (list)   |                                       |  |   |
| Other Exposure (list)   |                                       |  |   |
|   |                                       |  |   |

**Work Force Health Protection Measures; please indicate which of the following items you used during this deployment.**

- DEET insect repellent applied to skin
- Pesticide-treated uniforms/clothes
- Eye Protection (*Not commercial sunglasses or prescription glasses*)
- Hearing Protection: (*List protection used*): \_\_\_\_\_
- Respiratory Protection (*N95 or other respirator*): \_\_\_\_\_

Since your deployment, please check any of the following medical complaints that apply to you.

| Symptom<br>Check all that apply to you                 | FREQUENCY**<br>How often you experience the complaint - Often, Sometimes, Rare, Seasonally | Severity<br>On a scale of 1-10 (1=very mild, 10=severe health problem) rate each problem you check | New or Old<br>If this complaint is <b>NEW</b> , place the letter " <b>N</b> " in this column. If this condition is a <b>Worsening</b> of a previous/existing condition, place the letter " <b>O</b> " in this column. | Treatment<br>If you have seen a medical professional for this complaint, please list the Diagnosis and Medication you are taking. | Do you think this Symptom could be related to exposures at the Recovery Site?<br><br>Print YES or NO in this column for each symptom you have checked. |
|--|--|--|---|---|--|
| Fever  |  |  |   |   |  |
| Cough lasting more than 3 weeks                        |  |  |   |   |  |
| Trouble breathing                                      |  |  |   |   |  |
| Bad Headaches  |  |  |   |   |  |
| Generally feeling weak                                 |  |  |   |   |  |
| Muscle aches   |  |  |   |   |  |
| Swollen, stiff or painful joints                       |  |  |   |   |  |
| Numbness or tingling in hands or feet                  |  |  |   |   |  |
| Trouble hearing  |  |  |   |   |  |
| Ringing in the ears                                    |  |  |   |   |  |
| Watery, red eyes                                       |  |  |   |   |  |
| Dimming of vision, like the lights were going out      |  |  |   |   |  |
| Chest pain or pressure                                 |  |  |   |   |  |
| Dizzy, light headed, passed out                        |  |  |   |   |  |
| Diarrhea   |  |  |   |   |  |
| Vomiting   |  |  |   |   |  |
| Frequent indigestion/ heartburn                        |  |  |   |   |  |
| Trouble sleeping or still feeling tired after sleeping |  |  |   |   |  |
| Trouble concentrating, easily distracted               |  |  |   |   |  |
| Forgetful or trouble remembering things                |  |  |   |   |  |
| Increased irritability                                 |  |  |   |   |  |
| Skin diseases or rashes                                |  |  |   |   |  |

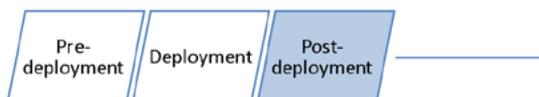


|  |  |  |  |  |  |
|--|--|--|--|--|--|
| Fatigue/Discomfort or multisystem complaints |  |  |  |  |  |
| Other: (Please list)                         |  |  |  |  |  |
| Other: (Please list)                         |  |  |  |  |  |

\*\* Often = Almost daily      Rare = less than monthly      Sometimes = 1-3 times a month  
 Seasonally = concentrated exposure during a predictable time period

**IMMUNIZATION STATUS**

1. Have you had a skin test for tuberculosis (PPD) within the last year?  Yes  No
  - a. Date of last PPD Skin Test: \_\_\_\_\_  
 Result:  Positive  Negative
2. Date of last Tetanus shot: \_\_\_\_\_
3. At any time during your deployment, were you exposed to human body fluids, tissue or organ material from a human (living or dead)?  
 Yes  No, if yes, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 • List personal protective equipment worn (if applicable): \_\_\_\_\_
4. Have you received the hepatitis B vaccine (HBV)?  Yes  No      If Yes, please list dates of immunization:  
 #1: \_\_\_\_\_  
 #2: \_\_\_\_\_  
 #3: \_\_\_\_\_
5. Did you receive vaccinations prior to your deployment?  Yes  No  
 If yes, please indicate the following vaccinations:  
 H1N1 Influenza  
 Seasonal Influenza  
 Typhoid  
 Meningococcal  
 Yellow Fever  
 Tetanus (Tdap)  
 Polio  
 MMR (*Measles, Mumps and Rubella*)  
 Hepatitis A (HAV)  
 Rabies



6. Were you told to take medicines to prevent malaria?  Yes  No
- a. If YES, please indicate which medicines you took and whether you missed any doses (*Mark all that apply*):
- Chloroquine (*Aralen*®)
  - Doxycycline (*Vibramycin*®)
  - Mefloquine
  - Primaquine
  - Malarone
  - Other: \_\_\_\_\_

If you have been or are experiencing mental or psychological health symptoms, such as claustrophobia, difficulty sleeping/nightmares, intense anger or outbursts, persistent thoughts, difficulty concentrating, withdrawal from work, family, friends, and activities, depression, or an increase in the consumption of alcohol, cigarettes or other substances, please obtain the assistance of a physician or mental health professional if you are not already seeking treatment. You can also obtain assistance through your component's Employee Assistance Program (EAP).

Did you complete Occupational Workman's Compensation Program (OWCP) forms?

- Yes  No

Were these forms submitted to the Employee Medical Programs office or equivalent?

- Yes  No (**If not, please submit with this Questionnaire**)

Have you filed OWCP forms with DOL to date for medical care or follow-up of any conditions listed on this form?  Yes  No

If Yes, please list the claim, the date claim was filed, and the location where claim was filed.

|    | <u>CLAIM</u> | <u>DATE FILED</u> | <u>LOCATION</u> |
|----|--------------|-------------------|-----------------|
| 1. | _____        | _____             | _____           |
| 2. | _____        | _____             | _____           |

Additional Comments \_\_\_\_\_

**Employee Signature** \_\_\_\_\_ **Date signed:** \_\_\_\_\_

