

# Separation Health Assessment

## Part A Self-Assessment

### Supplemental Guidance for Service Members

The following guidance is intended for Service members completing the SHA Self-Assessment (Part A of DD Form 3146 or the VA SHA DBQ) in electronic or print format.

### Contents

<b>Section I. Identification</b> .....	3
<b>A.I.1 Contact Information</b> .....	3
<b>A.I.2 Personal Information</b> .....	3
<b>A.I.3 Occupational Information</b> .....	3
<b>A.I.4 Examination Information</b> .....	3
<b>Section II. Report of Medical History</b> .....	4
<b>A.II.1 General Medical Review</b> .....	5
<b>A.II.2 Joint, Spine, &amp; Musculo-Skeletal System</b> .....	5
<b>A.II.3 Health &amp; Wellness</b> .....	5
<b>A.II.4 Hearing</b> .....	6
<b>A.II.5 Vision</b> .....	6
<b>A.II.6 Head Injury</b> .....	6
<b>A.II.7 Environmental/Occupational</b> .....	6
<b>A.II.8 Dental</b> .....	7
<b>A.II.9 Women’s Health/Female Reproductive Organs</b> .....	7
<b>A.II.10 Mental Health Screening Questionnaires</b> .....	8

## TABLE OF ACRONYMS

ACRONYM	DESCRIPTION
AD	Active Duty
AHOBPR	Airborne Hazards and Open Burn Pit Registry
AFSC	Air Force Specialty Code
AOC	Area of Concentration
BDD	Benefits Delivery at Discharge
C-section	Cesarean Section
COPD	Chronic Obstructive Pulmonary Disease
CPAP	Continuous Positive Airway Pressure Therapy
DBQ	Disability Benefits Questionnaire
DoB	Date of Birth
DoD	Department of Defense
EHR	Electronic Health Record
FDC	Fully Developed Claim
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
ID	Identification
IDES	Integrated Disability Evaluation System
IUD	Intrauterine Device
LEEP	Loop Electrosurgical Excision Procedure
MOS	Military Occupational Specialty
NEC	Naval Enlistment Code
Pap	Papanicolaou test
PCOS	Polycystic Ovarian Syndrome
PRK	Photorefractive keratectomy
PTSD	Post-Traumatic Stress Disorder
SHA	Separation Health Assessment
SSN	Social Security Number
TBI	Traumatic Brain Injury
VA	Department of Veterans Affairs
TMD	Temporomandibular Disorder
TMJ	Temporomandibular Joint

## SHA Part A – Self-Assessment

To be completed by the Service member.

### Section I. Identification

Answer all questions to the best of your ability.

#### A.1.1 Contact Information

Please ensure that valid contact information is provided so you can be reached for scheduling of any necessary examinations, tests, or follow-up communication. If you are planning to move, make sure you provide a cell phone number and personal email where you can be reached before, during, and after your move.

#### A.1.2 Personal Information

Answer all questions to the best of your ability.

#### A.1.3 Occupational Information

**Q4. Usual Occupation:** This refers to your job or duties performed during the most recent period of military service. Please note if your usual occupation is different than your military occupational specialty and for how long you were performing the duties of each.

#### A.1.4 Examination Information

**Q1. Examination Date:** This refers to the date you are scheduled for your in-person (face-to-face) physical examination. Leave blank if not known.

#### **Q3. Release from Active Duty date:**

- If you are a member of an active duty component, please provide the date you expect to separate from the active duty component.
- If you are a member of a reserve component who is (a) separating from active duty orders and then (b) retiring, being discharged or dismissed from the armed forces, or submitting a BDD claim to VA, please provide the end date of your active duty orders.
- If you do not know or cannot recall a specific date, then please provide an estimated date.

**Q4. Claim for Disability Compensation:** Select “yes” if you plan to file, or have already filed, a disability compensation claim with VA. **Do not** count claims for any other VA benefits you are currently receiving or have already received, such as VA Loans or Post-9/11 GI Bill.

**Q5. Type of Claim Program/Process:** If you selected “yes” in Q4, indicate the type of planned or pending disability compensation claim (if you know):

- **Fully Developed Claim (FDC) Program** is a VA process that allows you to file a claim within 90 days of release from active duty. The FDC Program requires **you** to provide VA with all evidence to support your claim at the beginning of the claim process. Evidence includes all personnel and medical records, including any private treatment records. VA will process your claim **after** your release from active duty, but processing is typically faster than for the Standard Claim Process (described below).
- **Integrated Disability Evaluation System (IDES)** is a dual DoD and VA disability evaluation process. The process is only available if you are referred by a military provider as part of a Physical Evaluation Board.
- **Benefits Delivery at Discharge (BDD) Program** is a VA claim process you may initiate while still on active duty. It is meant to help you complete the claims process sooner. To qualify for the BDD Program, you may file your claim **only** between 90-180 days **prior** to your release from active duty. If you have **less than** 90 days left on active duty, you can still file a disability claim with VA, but it will be evaluated under the Fully Developed Claim (FDC) or Standard Claim Process **after** your release from active duty.
- **Standard Claim Process** is a VA claim process you can utilize if you have **less than** 90 days until your release from active duty. With this process, VA helps you gather evidence (supporting documents such as private medical records) for your claim. Because of the time needed for VA to help you obtain evidence, the total processing time may be longer than for a FDC claim, where you collected that evidence before filing. Your Standard Claim will be processed **after** your release from active duty.
- Please check “not sure” if you have filed a claim, but you are unsure of which claim type.

**Q6. Prior Disability Claims:** Check “yes” if you have filed a disability claim with VA in the past. This question applies **ONLY** to past claims where service connection was granted or denied.

**Q7. Prior Physical Examination:** Check “yes” if you have had a comprehensive physical examination within the **12-month period prior to your release from active duty**. Provide the date and type of examination, and check “yes” if you would like the examination to be reviewed for possible satisfaction of SHA requirements. Examination types that **may** qualify include a prior SHA, an Entry Level Physical, a Flight Physical, or a Special Duty Physical. Your Examining Clinician will determine if your prior examination satisfies SHA requirements. If it does not, you will be asked to schedule an appointment for the physical examination portion of the SHA.

## Section II. Report of Medical History

Please complete all information in the medical history questionnaire as completely as possible. This information will be given to the Examining Clinician to review ahead of your appointment to allow adequate time for appraisal of your health history and concerns.

This is a screening questionnaire of your current health status and wellness. It gives you an opportunity to comment on any occupational exposures, injuries, illnesses, or health concerns you may have. For each response, please describe the history to the best of your ability, including dates of occurrence and treatment, as applicable.

If you are submitting a VA disability compensation claim, then VA will complete an appropriate evaluation, to include exams and completion of any necessary DBQs, to ensure that the information obtained is sufficient for rating purposes.

**NOTE:** “Qualifying military service” includes active duty; on orders 30 days or more in support of contingency operation(s); or on continuous active duty orders for 180 days or more. This includes active duty, any period of active duty for training, and any period of inactive duty.

### A.II.1 General Medical Review

**Q1. Current Medications and Supplements:** List all current prescription and over-the-counter medications and supplements, including those you may take for body building, workouts, energy, weight loss, vitamins, etc.

**Q2. Most Recent Military Medical Assessment / Physical Examination:** Enter the date, or the closest date you recall, of your most recent military medical assessment **with** a physical examination. If you feel your health is significantly better or worse than at the time of that examination, provide an explanation.

**Q4. Illness or Injury in the PAST MONTH:** If “yes,” please specify the illness or injury and what activity is affected. If more than one exists, specify each illness or injury and the activity affected.

**Q5. Hearing Aids, Special Medical Supplies, Equipment, Assistive Technology Devices, Special Accommodations:** Include all medically recommended/prescribed items, such as a hearing aid, a walker, a wrist brace for carpal tunnel, etc. Please indicate who recommended the item, when you wear or use it, and whether it is for your right or left side (if applicable).

**Q9. Physical or Mental Health Injury or Illness on Active Duty without Seeking Medical Care:** Explain the injury or illness, where it occurred (geographic location), approximately when (date), why you did not seek or receive medical care, and if you have any ongoing problems.

**Q10 – Q57. Other General Medical Items:** For each “yes” response, please state whether you received care for the condition, if you have any ongoing problems, and if you are currently seeing anyone for the condition (specify if primary care or specialist).

### A.II.2 Joint, Spine, & Musculo-Skeletal System

For each “yes” response, please state whether you received care for the condition, if you have any ongoing problems, and if you are currently seeing anyone for the condition (specify if primary care or specialist).

### A.II.3 Health & Wellness

Answer all questions to the best of your ability.

#### A.II.4 Hearing

Answer all questions to the best of your ability.

#### A.II.5 Vision

For each “yes” response, please state whether you received care for the condition, if you have any ongoing problems, and if you are currently seeing anyone for the condition. Please specify the type of provider; for example, a **primary care provider**; an **ophthalmologist** (a medical doctor or doctor of osteopathy who provides comprehensive eye care, including medical and surgical eye care); or an **optometrist** (a doctor of optometry who provides routine vision care and eye care services, but not surgical care).

**Q3. Corrective Surgery:** If you have had surgery to correct your vision, indicate the type of procedure, date, and hospital/clinic where the procedure was performed.

#### A.II.6 Head Injury

**Q1. Jolt or Blow to Head:** Check “yes” if you ever received a jolt or blow to your head that **IMMEDIATELY** caused one or more of the results listed. Place a check next to each result that occurred.

**Q2. Total Times:** On how many occasions did a jolt or blow to your head cause an immediate result such as losing consciousness, losing memory, or seeing stars? Give a numerical (1, 2, 3, etc.) response.

**Q3. Head Injury, Concussion or TBI:** If “yes,” please indicate if you were formally diagnosed with a concussion or traumatic brain injury (TBI). Include the date and location/facility of diagnosis, to the best of your ability as applicable. Please include specific details regarding the injury. Include the geographic location where the injury occurred, date of injury, and if you have ever been evaluated or treated for the injury (such as at a field hospital if it occurred during a deployment, or by a provider if due to an accident).

**Q4. Prolonged Symptoms:**

- As a result of an injury or event where you received a jolt or blow to your head, or were diagnosed with a TBI, do you have prolonged symptoms that have not resolved? If so, check “yes” and explain what those symptoms are and how often you experience them. For example, are the symptoms chronic (they are always present) or periodic (they come and go)?
- Please indicate if you are **currently experiencing** prolonged symptoms. If “yes,” indicate specifically what those symptoms are.

#### A.II.7 Environmental/Occupational

This section covers various potentially hazardous or unusual occupational and environmental exposures during qualifying military service. Exposures may have occurred while deployed, in training, or during other assignments.

You are asked to consider your potential exposure to burn pits, oil well fires, burning trash, dust storms, air pollution, explosions, fuels/fumes, pesticides/insecticides, cleaning agents, solvents, heavy metals/depleted uranium, nerve agents/gases, protective medication and vaccines (Pyridostigmine Bromide [PB], Lariam [Mefloquine] pills), persistent chemicals such as polychlorinated biphenyls [PCBs], asbestos, radiation, unusual food/drinking water exposures, contaminated water, and personal hygiene exposures (swimming, showering, etc.).

This form provides information to assist you in understanding your eligibility for enrollment in the VA Airborne Hazards and Open Burn Pit Registry (AHOBPR), which is separate from compensation and benefits evaluations. The AHOBPR is open to all Service members and Veterans who deployed to contingency operations in the Southwest Asia theater of operations at any time on or after August 2, 1990; or to Afghanistan or Djibouti on or after September 11, 2001. These regions include the following countries and bodies of water, and the airspace above these locations: Iraq, Afghanistan, Kuwait, Saudi Arabia, Bahrain, Djibouti, Gulf of Aden, Gulf of Oman, Oman, Qatar, and the United Arab Emirates; and waters of the Persian Gulf, Arabian Sea, Red Sea, Uzbekistan, and Syria. VA will use deployment data provided by DoD to determine eligibility. You may join the AHOBPR even if:

- You don't think, or are unsure if, you were exposed to specific airborne hazards.
- You are not experiencing symptoms or illnesses you think are related to your exposures.
- You have not filed a VA claim for compensation and benefits or applied for VA health care.
- You are still an active duty Service member, reservist, or have returned to active service.

Visit [www.publichealth.VA.gov/airbornehazards](http://www.publichealth.VA.gov/airbornehazards) to learn more about airborne hazards and the registry.

Service members who are not eligible for the registry but are concerned about their exposures can still apply for VA health care and file a claim for compensation and benefits.

### A.II.8 Dental

For each "yes" response, please state whether you received care for any condition, if you have any ongoing problems, and if you are currently receiving treatment for the condition (specify type of provider).

### A.II.9 Women's Health/Female Reproductive Organs

You may skip this section if it is not applicable. Please check "not applicable" at the top of the section.

**Q2. Details of Disorders:** For each disorder identified in Q1, please indicate if you are still undergoing active treatment. Include the date of diagnosis, treatment, medications, and treatment center.

**Q4. Details of Surgeries and Injuries:** For each surgery and injury identified in Q3, please indicate if you are still undergoing active treatment. Include the date of diagnosis, treatment center, and treating provider(s) as applicable.

**Q5. Pregnancy:** Use a separate date line for each pregnancy. More than one outcome/condition box may be selected for each date as applicable (for example, you may have had a vaginal delivery with a complication of post-partum depression, so you would select both boxes). Please provide any additional information (such as an explanation of “Other”) in the space provided.

**Q7. Mammogram with Abnormal Result:** For any abnormal findings, please indicate if you are still under surveillance or need any further follow up testing or care.

**Q9. Cervical Cancer Screening with Abnormal Result:** For any abnormal findings, please indicate if you are still under surveillance or need any further follow up testing or care.

#### **A.II.10 Mental Health Screening Questionnaires**

Please complete all information in the mental health screening questionnaires. Responses will be reviewed by the Examining Clinician and additional questions may be asked.

Answer all questions to the best of your ability.

***NOTE: If you are struggling with any mental health concerns and would like to speak to someone confidentially, please call the Veterans Crisis Line at 988 and press ‘1’ or text 838255.***

---

**You have reached the end of the Self-Assessment. Please review your responses for accuracy and completeness. Correct any answers as needed. Once you are finished, sign and date this form then submit as directed.**

---