DEPARTMENT OF HOMELAND SECURITY
U.S. COAST GUARD

MODIFIED SCREENING FOR: OVERSEAS ASSIGNMENT AND/OR SEA DUTY HEALTH SCREENING

PRIVACY ACT STATEMENT

AUTHORITY: The authority for collection of information including social security number (SSN) is found in the Privacy Act of 1974, 5 U.S. .C. § 552a.

PURPOSE: The purpose of this form is to facilitate determining a member's suitability while on PCS orders overseas. This includes ascertaining if the member understands, is fully prepared for living at the location, and medical or related needs can be met by a Military Treatment Facility (MTF) or TRICARE authorized provider.

ROUTINE USE: Information will be used by personnel within the Coast Guard to determine a member's suitability for traveling on PCS orders overseas.

DISCLOSURE: In the case of military personnel, the requested information is mandatory. Failure to respond may preclude successful processing of an application for PCS travel overseas and/or Command sponsorship and may lead to administrative or disciplinary action against the member.

A. EXAMINEE DATA

Name *(Last, First, Middle Initial)*	Rate/Rank	Social Security Number	Unit

Examining Facility	Purpose of Screening	Transfer/Deployment Location	Date

B. HEALTH HISTORY *(completed by examinee)*

1. Would you say your health in general is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. Do you have any medical or dental problems or concerns? ☐ No ☐ Yes
3. Do you have any health related duty limitations? ☐ No ☐ Yes
4. Could you be pregnant? *(females request HCG if needed)* ☐ Unknown ☐ N/A ☐ No ☐ Yes
5. Are you taking prescription medications? *(request refills if needed)* ☐ No ☐ Yes
6. During the past year, have you sought or required counseling or mental health care? ☐ No ☐ Yes
7. Explain any "fair, poor, yes, or unknown" responses:

8. Have you been hospitalized since your last Periodic Health Assessment (PHA)?
☐ Yes ☐ No *If (Yes), explain.*

I certify that the responses above are true:

Signature of Examinee

C. PERIODIC HEALTH ASSESSMENT (PHA) REVIEW *(current approved PHA required)*

9. Date of most recent PHA:
10. Status of recommendations or further specialist examination:
11. Summary of significant health history since last PHA:

D. HEALTH RECORD & INDIVIDUAL MEDICAL READINESS REVIEW

12. Have routine gynecologic (pap) examinations been completed in the past year? *(females)* ☐ N/A ☐ No ☐ Yes
13. Does examinee have two pair of glasses? *(if required)* ☐ N/A ☐ No ☐ Yes
14. Does deployable member have a gas mask insert? *(if required)* ☐ N/A ☐ No ☐ Yes
15. Has DNA sampling been completed and documented? *(once per career)* ☐ No ☐ Yes
16. Has G-6PD screening been completed and documented? *(once per career)* ☐ No ☐ Yes
17. Are immunizations up-to-date and meet requirements for destination? ☐ No ☐ Yes
18. Has an HIV test been drawn (with negative results) in the past 6 months? *(foreign country PCS only)* ☐ N/A ☐ No ☐ Yes
19. Has a baseline TST been completed and documented? ☐ No ☐ Yes
20. Have specific force health protection requirements been met (e.g. malaria chemoprophylaxis)? ☐ N/A ☐ No ☐ Yes
21. Has a Type 2 dental examination been completed in the past year and is examinee "Class 1 or 2"? ☐ No ☐ Yes
22. Explain any "no" answers: _____

Contact the Centers for Disease Control and Prevention at http://www.cdc.gov and; the National Center for Medical Intelligence at https://www.intelink.gov/ncmi/index.php

E. SIGNATURE *(Medical and Dental Provider or IDHS)*

Medical Provider/IDHS Signature/Stamp:	**Dental Provider/IDHS** Signature/Stamp:
Date Signed:	Date Signed:

F. APPROVAL/DISAPPROVAL *(Clinic Administrator)*

Reviewing/Approving Authority Signature/Stamp:	☐ **Approved** ☐ **Disapproved**