

*Veterans - Military and Occupational Assessment
Tool (V-MOAT)*

A. MILITARY DEMOGRAPHICS: (Please check the answer that best applies) (SECTION A not included if WRIISC intake packet used)

1. MILITARY SERVICE:

| Please list start and separation dates for all military service | | | | | |
|---|------------------|----------------|----------------------|------------------|----------------|
| SERVICE | MONTH/YEAR START | MONTH/YEAR END | SERVICE | MONTH/YEAR START | MONTH/YEAR END |
| Army | MM / YYYY | MM / YYYY | Air Force | MM / YYYY | MM / YYYY |
| Army Reserve | MM / YYYY | MM / YYYY | Air Force Reserve | MM / YYYY | MM / YYYY |
| Army National Guard | MM / YYYY | MM / YYYY | Air National Guard | MM / YYYY | MM / YYYY |
| Navy | MM / YYYY | MM / YYYY | Marine Corps | MM / YYYY | MM / YYYY |
| Navy Reserve | MM / YYYY | MM / YYYY | Marine Corps Reserve | MM / YYYY | MM / YYYY |
| Coast Guard | MM / YYYY | MM / YYYY | Coast Guard Reserve | MM / YYYY | MM / YYYY |
| Public Health | MM / YYYY | MM / YYYY | Other (_____) | MM / YYYY | MM / YYYY |

2. LAST PAY GRADE (e.g., E5, O4, W3, etc.): _____

3. PRIMARY AND SECONDARY MILITARY OCCUPATIONS (e.g., MOS, NEC, AFSC):

| TITLE/DESCRIPTION | MONTH/YEAR | | TO | MONTH/YEAR |
|-------------------|------------|--|----|------------|
| | MM / YYYY | | to | MM / YYYY |
| | MM / YYYY | | to | MM / YYYY |
| | MM / YYYY | | to | MM / YYYY |

4. MILITARY DEPLOYMENTS:

Please provide Dates, Location, and Job Duties for ALL deployments (Use Key below for Conflict Code):

| DEPLOYMENT | | MONTH | YEAR | LOCATION(S) | CONFLICT CODE (See below) | MILITARY JOB DUTIES (If different from previous page) |
|------------|-------|-------|------|-------------|------------------------------|--|
| #1 | START | MM | YYYY | | | |
| | END | | | | | |
| #2 | START | MM | YYYY | | | |
| | END | | | | | |
| #3 | START | MM | YYYY | | | |
| | END | | | | | |
| #4 | START | MM | YYYY | | | |
| | END | | | | | |
| #5 | START | MM | YYYY | | | |
| | END | | | | | |

| CONFLICT CODES: | | | | | |
|--|-----------|-------------|-------------------------|--------------|--------------|
| 1 = WWII | 2 = Korea | 3 = Vietnam | 4 = Lebanon | 5 = Panama | 6 = Grenada |
| 7 = Operation Desert Storm/Desert Shield | | 8 = Kosovo | 9 = Bosnia | 10 = Croatia | 11 = Somalia |
| 12 = OEF | | 13 = OIF | 14 = Operation New Dawn | | |
| 15 = Other: _____ | | | | | |

B. MILITARY AND OCCUPATIONAL EXPOSURE HISTORY:

Please indicate if you were exposed to any of the exposures listed in the far-left column. If exposed, please answer additional questions listed in the following columns.

| Type of exposure | Examples of this type of exposure include: | Examples of work settings where exposure could occur: | Did you have a job where you were exposed? | Over what period of time did the exposure occur? | How were you exposed? (list all that apply) | In what job were you exposed? | How often were you exposed? | Did you wear personal protection when you were exposed? | Did you have health effects at time of exposure? | How concerned are you about this exposure? | Comments: |
|------------------|--|---|--|--|--|---|--|---|--|---|---|
| | | | 1 -Yes 2 -No 3 -Don't know | Start: MM/YR End: MM/YR | 1-Breathing 2-Skin Contact 3-Eating or drinking, by mouth 4-Eye Contact 5-Injection 6-Other | 1- Military job 2- Civilian job 3- Both | 1 -Very often (daily to weekly) 2- Often (1-4 times/month) 3- Sometimes (once/month to once/6 months) 4- Rarely (once/year or less) | 1 -Yes If yes, what? -Gloves -Mask -Respirator -Eyewear -Protective suit, -Headgear -Other 2 -No | 1 -No noticeable health effects 2 -Mild effects or symptoms that did not affect ability to conduct physical activities. Examples: mild eye or throat irritation, strange odors. 3 -Moderate effects or symptoms that had some effect on physical activity. Examples: notable coughing or eye irritation; some difficulty breathing; or mild dizziness and nausea. 4 -Severe effects to include those described above but that were so debilitating, they severely impaired physical activity and/or required medical treatment. | 1 -Not concerned 2 - Somewhat concerned 3 -Very concerned | Please provide details of any health effects or concerns. |

| | | | | | | | | | | | | |
|---|---|---|--|--|--|--|--|--|--|--|--|--|
| <p><u>Perfluoroalkyl and polyfluoroalkyl substances (PFAS or PFOA)</u></p> | <p>Synthetic chemicals found in many products, such as clothing, carpets, fabrics for furniture, adhesives, paper packaging for food, and heat-resistant/non-stick cookware. Also present in fire-fighting foams (or aqueous film forming foam; AFFF) used by firefighters.</p> | <p>Firefighters</p> | | | | | | | | | | |
| <p><u>Solvents, Industrial</u></p> | <p>Acetone</p> | <p>Used to make plastic, fibers, drugs, and other chemicals. used to dissolve other substances. Occurs naturally in plants, trees, volcanic gases, forest fires. Present in vehicle exhaust, tobacco smoke, and landfill sites.</p> | | | | | | | | | | |
| | <p>Benzene</p> | <p>Manufacture of plastics, resins, other synthetic fibers. Used in rubbers, dyes/lubricants. Natural emission sources include volcanic ash and forest fires. Natural part of crude oil, cigarette smoke, gasoline.</p> | | | | | | | | | | |
| | <p>Tetrachloroethylene</p> | <p>Used as dry-cleaning agent and metal degreasing solvent. Used to make other chemicals and in some consumer products.</p> | | | | | | | | | | |

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|----------------------|------------------------|----------------------|--|--|--|--|--|--|--|--|
| Sexual Trauma | Military Sexual Trauma | Sexual Assault, Rape | | | | | | | | |
|----------------------|------------------------|----------------------|--|--|--|--|--|--|--|--|

6. HEALTH PREVENTIVE MEASURES

| Type of Preventive Measure | Examples of health preventive measure: | Examples of when health preventive measure used: | Did you have a job where you received this health preventive measure? | If Yes, list when taken: | If taken, how many times taken? | If taken, when did you take? | If taken, did you have health effects at time? | How concerned are you about this exposure? | Comments: Please provide details of any health effects or concerns. |
|---------------------------------------|--|---|--|----------------------------------|--|--|---|--|--|
| | | | 1 -Yes 2 -No 3 -Don't know | Start: MM/YR End: MM/YR | 1-Rarely, 1-2 times 2-Occasionally (few weeks up to a month) 3-Often (used for several months up to a year) 4-Frequently (used on regular basis over many years) | 1 – during military job 2 – during civilian job 3 - both | 1 -No 2 -Mild 3 -Moderate 4 -Severe | 1 -Not concerned 2 -Moderately concerned 3 -Very concerned | |
| Vaccinations | Anthrax | Anthrax vaccine used during deployments to Persian Gulf and Afghanistan | | | | | | | |
| Anti-Malarial Medications | Doxycyline, Mefloquine Primaquine Atovaquone-proguanil (Malarone), Chloroquine, other antimalarial | Antimalarials used for deployments to Somalia, Africa, Afghanistan | | | | | | | |
| Pesticides | DEET, permetherin | Commonly used in field training or deployments | | | | | | | |
| Pyridostigmine Bromide Tablets | Use during Gulf War 1 (1990-1991) | Nerve agent preventive medication used | | | | | | | |

HOBBIES AND NON-OCCUPATIONAL EXPOSURES: (Please indicate if you have ever performed any of these activities. If yes, please answer the following questions)

| | Have you participated in this activity frequently over any 6-month period? | If yes, did you wear any personal protection during these activities such as headgear, masks, boots, gloves, or other protective equipment? | Did you have health effects at time of exposure? |
|---|---|--|---|
| 1. Painting or Renovating your home | <input type="checkbox"/> Yes, within the past 10 years <input type="checkbox"/> Yes, but more than 10 years ago <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes | 1 -No noticeable health effects 2 -Mild effects or symptoms that did not affect ability to conduct physical activities. Examples: mild eye or throat irritation, strange odors. 3 -Moderate effects or symptoms that had some effect on physical activity. Examples: notable coughing or eye irritation; some difficulty breathing; or mild dizziness and nausea. 4 -Severe effects to include those described above but that were so debilitating, they severely impaired physical activity and/or required medical treatment |
| 2. Furniture Making or Refinishing | <input type="checkbox"/> Yes, within the past 10 years <input type="checkbox"/> Yes, but more than 10 years ago <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes | 1 -No noticeable health effects 2 -Mild effects or symptoms that did not affect ability to conduct physical activities. Examples: mild eye or throat irritation, strange odors. 3 -Moderate effects or symptoms that had some effect on physical activity. Examples: notable coughing or eye irritation; some difficulty breathing; or mild dizziness and nausea. 4 -Severe effects to include those described above but that were so debilitating, they severely impaired physical activity and/or required medical treatment |
| 3. Woodworking or sanding stone/granite/marble | <input type="checkbox"/> Yes, within the past 10 years <input type="checkbox"/> Yes, but more than 10 years ago <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes | 1 -No noticeable health effects 2 -Mild effects or symptoms that did not affect ability to conduct physical activities. Examples: mild eye or throat irritation, strange odors. 3 -Moderate effects or symptoms that had some effect on physical activity. Examples: notable coughing or eye irritation; some difficulty breathing; or mild dizziness and nausea. 4 -Severe effects to include those described above but that were so debilitating, they severely impaired physical activity and/or required medical treatment |
| 4. Auto Repair or Body Work | <input type="checkbox"/> Yes, within the past 10 years <input type="checkbox"/> Yes, but more than 10 years ago <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes | 1 -No noticeable health effects 2 -Mild effects or symptoms that did not affect ability to conduct physical activities. Examples: mild eye or throat irritation, strange odors. 3 -Moderate effects or symptoms that had some effect on physical activity. Examples: notable coughing or eye irritation; some difficulty breathing; or mild dizziness and nausea. 4 -Severe effects to include those described above but that were so debilitating, they severely impaired physical activity and/or required medical treatment |
| 5. Work with Glues, Solvents, or Chemicals (such as those used in model building, fiberglass repair, etc.) | <input type="checkbox"/> Yes, within the past 10 years <input type="checkbox"/> Yes, but more than 10 years ago <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes | 1 -No noticeable health effects 2 -Mild effects or symptoms that did not affect ability to conduct physical activities. Examples: mild eye or throat irritation, strange odors. 3 -Moderate effects or symptoms that had some effect on physical activity. Examples: notable coughing |

| | | | |
|--|---|---|---|
| | | | or eye irritation; some difficulty breathing; or mild dizziness and nausea. 4 -Severe effects to include those described above but that were so debilitating, they severely impaired physical activity and/or required medical treatment |
| 6. Pesticides while gardening or farming | <input type="checkbox"/> Yes, within the past 10 years <input type="checkbox"/> Yes, but more than 10 years ago <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes | 1 -No noticeable health effects 2 -Mild effects or symptoms that did not affect ability to conduct physical activities. Examples: mild eye or throat irritation, strange odors. 3 -Moderate effects or symptoms that had some effect on physical activity. Examples: notable coughing or eye irritation; some difficulty breathing; or mild dizziness and nausea. 4 -Severe effects to include those described above but that were so debilitating, they severely impaired physical activity and/or required medical treatment |
| 7. Jewelry making, pottery work, studio painting, stained glass windows | <input type="checkbox"/> Yes, within the past 10 years <input type="checkbox"/> Yes, but more than 10 years ago <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes | 1 -No noticeable health effects 2 -Mild effects or symptoms that did not affect ability to conduct physical activities. Examples: mild eye or throat irritation, strange odors. 3 -Moderate effects or symptoms that had some effect on physical activity. Examples: notable coughing or eye irritation; some difficulty breathing; or mild dizziness and nausea. 4 -Severe effects to include those described above but that were so debilitating, they severely impaired physical activity and/or required medical treatment |
| 8. Physical Extreme sports (mountain climbing, scuba diving, parachuting) | <input type="checkbox"/> Yes, within the past 10 years <input type="checkbox"/> Yes, but more than 10 years ago <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes | 1 -No noticeable health effects 2 -Mild effects or symptoms that did not affect ability to conduct physical activities. 3 -Moderate effects or symptoms that had some effect on physical activity. 4 -Severe effects that were so debilitating, they severely impaired physical activity and/or required medical treatment |
| 9. Contact athletics (martial arts, MMA, boxing, rugby) | <input type="checkbox"/> Yes, within the past 10 years <input type="checkbox"/> Yes, but more than 10 years ago <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes | 1 -No noticeable health effects 2 -Mild effects or symptoms that did not affect ability to conduct physical activities. 3 -Moderate effects or symptoms that had some effect on physical activity. 4 -Severe effects to include debilitating effects that severely impaired physical activity and/or required medical treatment |
| 10. Endurance athletics (tri-athlete, marathons) | <input type="checkbox"/> Yes, within the past 10 years <input type="checkbox"/> Yes, but more than 10 years ago <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes | 1 -No noticeable health effects 2 -Mild effects or symptoms that did not affect ability to conduct physical activities. 3 -Moderate effects or symptoms that had some effect on physical activity. 4 -Severe effects to include those that were debilitating that severely impaired physical activity and/or required medical treatment |