

MILITARY HISTORY CHECKLIST

PATIENT DATA

Patient's Name:	Date:	
Address:	Hospice Medical Record #:	Last 4 SSN:

VETERAN STATUS INFORMATION

1. Did you (or your spouse or family member) serve in the military?

1a. Patient	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did you serve on active duty?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Did your service include combat duty?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		Do you have a copy of your DD214 discharge papers?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1b. Did your spouse serve on active duty?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:			
1c. Do you have any immediate family members that served or are serving in the military?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Comments:			

MILITARY BACKGROUND

2. In which branch of the military did you serve?

<input type="checkbox"/> Army	<input type="checkbox"/> Marines	<input type="checkbox"/> Merchant Marines during WWII
<input type="checkbox"/> Navy	<input type="checkbox"/> Coast Guard	<input type="checkbox"/> Other _____
<input type="checkbox"/> Air Force	<input type="checkbox"/> Reservist or National Guard member	

3. In which war era or period of service did you serve?

<input type="checkbox"/> WWI (4/6/17 to 11/11/18)	<input type="checkbox"/> Vietnam (8/5/64 to 5/7/75 and 2/28/61 for veterans who served "in country" (in Vietnam) before 8/5/64)	<input type="checkbox"/> Peace Time
<input type="checkbox"/> WWII (12/7/41 to 12/31/46)	<input type="checkbox"/> Gulf War (8/2/90 through a date to be set by law or presidential proclamation)	<input type="checkbox"/> Afghanistan/Iraq (OEF/OIF)
<input type="checkbox"/> Korea (6/27/50 to 1/31/55)		<input type="checkbox"/> Other
<input type="checkbox"/> Cold War		Note: after 9/7/80, must have completed 24 months continuous active service, or the full period for which they were called or ordered to active duty.

4. Overall, how do you view your experience in the military?

5. If available would you like your hospice staff/volunteer to have military experience? Yes No

VA BENEFITS INFORMATION

6. Are you enrolled in VA?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6a. Do you receive any VA benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6b. Do you have a service-connected condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6c. Do you get your medications from VA?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6d. What is the name of your VA hospital or clinic?	
6e. What is the name and contact information of your VA physician or Primary Care Provider?	
6f. Would you like to talk with someone about benefits you or your family might be eligible to receive? <input type="checkbox"/> Yes <input type="checkbox"/> No	