

Supplemental Table S1. VHA TBI Screening Tool.

<p>1. During any of your OIF/OEF deployment(s), did you experience any of the following events?</p> <p>2. Did you have any of these immediately afterwards?</p> <p>3. Did any of the following problems begin or get worse afterwards?</p>	<p>1 <input type="checkbox"/> Blast or explosion (IED, RPG, Landmine, Grenade, etc)</p> <p>2 <input type="checkbox"/> Vehicular accident/crash (any vehicle including aircraft)</p> <p>3 <input type="checkbox"/> Fragment wound or bullet wound above the shoulders</p> <p>4 <input type="checkbox"/> Fall</p> <p>5 <input type="checkbox"/> Blow to head (head hit by falling/flying object, head hit by another person, head hit against something, etc)</p> <p>1 <input type="checkbox"/> Losing consciousness/"knocked out"</p> <p>2 <input type="checkbox"/> Being dazed, confused, or "seeing stars"</p> <p>3 <input type="checkbox"/> Not remembering the event</p> <p>4 <input type="checkbox"/> Concussion</p> <p>5 <input type="checkbox"/> Head injury</p> <p>1 <input type="checkbox"/> Memory problems or lapses</p> <p>2 <input type="checkbox"/> Balance problems or dizziness</p> <p>3 <input type="checkbox"/> Sensitivity to bright light</p> <p>4 <input type="checkbox"/> Irritability</p> <p>5 <input type="checkbox"/> Headaches</p> <p>6 <input type="checkbox"/> Sleep problems</p>
<p>4. In the past week, have you had any of the symptoms from Section 3?</p>	<p>1 <input type="checkbox"/> Memory problems or lapses</p> <p>2 <input type="checkbox"/> Balance problems or dizziness</p> <p>3 <input type="checkbox"/> Sensitivity to bright light</p> <p>4 <input type="checkbox"/> Irritability</p> <p>5 <input type="checkbox"/> Headaches</p> <p>6 <input type="checkbox"/> Sleep problems</p>