

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

PRIVACY ACT STATEMENT: This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed. **HSWL EHR was not accessible during this patient visit.**

DATE: _____

ROS: Check as indicated. Patient denies unchecked items.

<input type="checkbox"/> Fever <input type="checkbox"/> Chills	<input type="checkbox"/> Wt Loss / <input type="checkbox"/> Gain	<input type="checkbox"/> Headache	<input type="checkbox"/> Lightheadedness	<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Nasal Discharge	<input type="checkbox"/> Nasal Blockage
<input type="checkbox"/> Earache	<input type="checkbox"/> Nausea/ <input type="checkbox"/> Vomiting	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Heat <input type="checkbox"/> Cold Intol
<input type="checkbox"/> Chest pain	<input type="checkbox"/> SOB	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Dysuria	<input type="checkbox"/> Urinary Urgency	<input type="checkbox"/> Urinary Frequency

SUBJECTIVE: See DD Form 2807-1 (in AERO) Pt's rate: Telephone Consult (time: 5-10, 11-20, 21-30 min)
BP: **H/R:** **O2:** **RR:** **HT:** **WT:** **Pain:** **Temp:**

OBJECTIVE: Mark n/a or normal as indicated. Circle positive findings and elaborate after checking Abn or in free text box pg 2.

General	<input type="checkbox"/> N/a <input type="checkbox"/> Nml: (Well Developed, Well Nourished, Not Distressed, Not Diaphoretic) <input type="checkbox"/> Abn
Eyes	<input type="checkbox"/> N/a <input type="checkbox"/> PERLL <input type="checkbox"/> Nml: (Conj, EOMI, Conj/Sclera Erythema, No Discharge) <input type="checkbox"/> Abn
Ears	<input type="checkbox"/> N/a <input type="checkbox"/> Nml (Outer Ear/Canal, No discharge, TM nml) <input type="checkbox"/> TM Mobility Nml Bilat <input type="checkbox"/> Abn
Nose/Throat	<input type="checkbox"/> N/a <input type="checkbox"/> Nml (No Discharge, Edema, Erythema) <input type="checkbox"/> Nml: (Oropharynx Clear & Moist, No erythema, exudates) <input type="checkbox"/> Abn
Neck	<input type="checkbox"/> N/a <input type="checkbox"/> Nml (Supple, Full ROM, Nontender) <input type="checkbox"/> Thyroid Nml <input type="checkbox"/> Carotid w/o bruits <input type="checkbox"/> Nml Lymph Node <input type="checkbox"/> Abn
Cardiovascular	<input type="checkbox"/> N/a <input type="checkbox"/> Nml (S1, S2, no S3,S4. No murmurs, rubs) Distal pulses: <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ <input type="checkbox"/> Abn
Lungs/Chest	<input type="checkbox"/> N/a <input type="checkbox"/> Nml (No distress, Nml Breath Sounds, No Wheezing, Rales or Chest Tenderness) <input type="checkbox"/> Abn
Abdomen	<input type="checkbox"/> N/a <input type="checkbox"/> Nml (Soft, NT, Nml Bowel Sounds, No rebound, guarding, distention) <input type="checkbox"/> No Organomegaly <input type="checkbox"/> Abn
Genitalia: Male	<input type="checkbox"/> N/a <input type="checkbox"/> Penis Nml <input type="checkbox"/> Testes Nml <input type="checkbox"/> Prostate Nml <input type="checkbox"/> No hernia present <input type="checkbox"/> Abn
Female	<input type="checkbox"/> N/a <input type="checkbox"/> Nml (Vulva, Vagina) <input type="checkbox"/> No Abn Discharge PAP: Cervix <input type="checkbox"/> Nml (Nontender, No Erythema, Lesion) <input type="checkbox"/> IUD string present <input type="checkbox"/> Adnexal Tenderness / Mass <input type="checkbox"/> Cystocele/Rectocele Breasts: <input type="checkbox"/> Nml (Apperance, No Discharge, Nodules, Nontender, No Dimpling/Retraction/Discharge) <input type="checkbox"/> Axillary Node Enlrgmt <input type="checkbox"/> Abn
Rectal	<input type="checkbox"/> N/a <input type="checkbox"/> Nml (Appearance, Tone) <input type="checkbox"/> No Hemorrhoids / Lesions <input type="checkbox"/> Guaiac: Neg <input type="checkbox"/> Abn
Musculoskeletal	<input type="checkbox"/> N/a <input type="checkbox"/> Full ROM <input type="checkbox"/> 5/5 Strength <input type="checkbox"/> Abn
Neuro/Psych	<input type="checkbox"/> N/a <input type="checkbox"/> Alert/Oriented X3 <input type="checkbox"/> Neuro Nml (Gait, Stance, Balance, Sensation) <input type="checkbox"/> CN II-XII Nml DTR: <input type="checkbox"/> 1+ <input type="checkbox"/> 2+ <input type="checkbox"/> 3+ <input type="checkbox"/> 4+ <input type="checkbox"/> Nml Mood/ Affect <input type="checkbox"/> Abn
Skin	<input type="checkbox"/> N/a <input type="checkbox"/> Nml (No Lesions, Bruising, Rash, Temperature Nml) <input type="checkbox"/> Abn

HOSPITAL OR MEDICAL FACILITY	STATUS/ RATE/ RANK	DEPARTMENT/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	FULL SOCIAL SECURITY	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)

DATE OF BIRTH / AGE	WARD NUMBER
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OBJECTIVE Cont (as needed): See DD Form 2808 in AERO

ASSESSMENT/PLAN: (incl ICD10 & E&M code): Medications reconciled/dispensed as noted on Page 1 of SF600 questionnaire.

PROCEDURES (ICD 10):

DUTY STATUS: Fit for full Duty SIQ X _____ Limited Duty X _____ Days TLD MEB

- Follow up as instructed in _____ days, or PRN, with clinic or consultant.
- Discussed diagnosis, medications/treatments, alternatives, potential side effects with the patient who indicated understanding.
- Reviewed PMH, family and social history, meds, chronic conditions, healthy lifestyle choices with patient as indicated or appropriate. Reviewed problem summary or 2766.

MO Signature & Stamp: _____

Name (last, first, MI): _____

SSN: _____