

HEALTH RECORD

SYPHILIS RECORD

SECTION I. - HISTORY OF PAST VENEREAL INFECTIONS OR TREATMENTS

	DATE	DISEASE <i>(Give stage)</i>	PRIOR TO MIL. SERVICE		TREATMENT <i>(Give type, amount and dates)</i>	TREATING AGENCY	PLACE
			YES	NO			
1							
2							
3							
4							

SECTION II. - HISTORY OF PRESENT INFECTION

CAME TO MEDICAL ATTENTION BY: VOLUNTARY CONTACT REPORT PHYSICAL INSPECTION FOOD HANDLER

INCIDENT TO HOSPITALIZATION PREMARITAL PRENATAL OTHER *(Specify)*

DATES: ONSET SYMPTOMS REQUESTED TREATMENT DIAGNOSIS ESTABLISHED

DIAGNOSIS <i>(Include stage and diagnosis No.)</i> LIST VD CONTACT FORM SERIAL NOS.	DIAGNOSTIC CRITERIA <i>(Enter results of tests)</i> DARKFIELD S.T.S. SPINAL FLUID <i>(If indicated)</i> OTHER <i>(List)</i>
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CLINICAL DATA *(Include chief complaint, physical findings - eye, cardiovascular and nervous system, even in early syphilis)*

RECOMMENDED TREATMENT AND FOLLOW-UP	SIGNATURE OF PHYSICIAN	DATE
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HAVE BEEN INFORMED BY THE MEDICAL OFFICER THAT I HAVE BEEN DIAGNOSED AS HAVING SYPHILIS AS INDICATED ABOVE; THE NATURE OF THIS DISEASE HAS BEEN EXPLAINED TO ME; I UNDERSTAND THAT MY COOPERATION IS NECESSARY IN THE TREATMENT AND PROLONGED OBSERVATION *(including certain prescribed tests)* FOR THE CARE OF THIS DISEASE.

SIGNATURE OF PATIENT AND DATE

SECTION III. - TREATMENT

	TREATMENT	DATE STARTED	DATE ENDED	SIGNATURE OF PHYSICIAN
1				
2				
3				
4				

PATIENT'S IDENTIFICATION *(Mechanically Imprint, Type or Print)* :

- ◀ Patient's Name - last, first, middle initial; Sex; Age or Year of Birth; Relationship to Sponsor; Component/Status; Department/Service.
- ◀ Sponsor's Name - last, first, middle initial Rank/Grade; SSN or Identification Number; Organization.

SECTION IV. - CUMULATIVE LABORATORY SUMMARY

RESULTS OF DARKFIELD EXAMINATION

	DATE	RESULTS	SOURCE OF SPECIMEN	LABORATORY	NAME OF CONFIRMING OFFICER
1					
2					

RESULTS OF SEROLOGICAL TESTS FOR SYPHILIS

	DATE	TYPE	RESULT (Include titer value)	LABORATORY		DATE	TYPE	RESULT (Include titer value)	LABORATORY
1					5				
2					6				
3					7				
4					8				

FLUORESCENT ANTIBODY TESTS

	DATE	
1		
2		

RESULTS OF SPINAL FLUID EXAMINATIONS

	DATE	CELLS	TOTAL PROTEIN	SEROLOGICAL TESTS (Including titer)	LABORATORY WHERE DONE
1					
2					

SECTION V. - EVALUATION OF THERAPY

	DATE	FACILITY WHERE EVALUATED	RESULT		DATE OF RETREATMENT	PHYSICIAN'S SIGNATURE
			Satisfactory*	UNSATISFACTORY**		
1						
2						
3						
4						

*Satisfactory result cannot be reported without normal spinal fluid findings.

**Specify: Infectious Relapse; Sero-Relapse, Neuro-Relapse, Incomplete data on Spinal Fluid, Other (Specify)

REASON FOR INADEQUATE FOLLOW-UP (Date, place and type of separation - Give authority for discharge)

PATIENT'S HOME ADDRESS ON SEPARATION

CIVILIAN HEALTH DEPT. TO WHICH CASE RESUME WAS SENT

REINFECTION (Give date new record was opened)

REMARKS (Include significant posttreatment clinical findings)

SECTION VI. - MEDICAL OFFICER CLOSING THIS RECORD

NAME (Typed or printed)	SIGNATURE	STATION	DATE
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SECTION VII. - MEDICAL OFFICER SENDING ABSTRACT TO VETERAN'S ADMINISTRATION ON DISCHARGE

NAME (Typed or printed)	SIGNATURE	STATION	DATE
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