

Health Record		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (<i>Sign each entry</i>)		
OVERSEAS SCREENING			
PLEASE COMPLETE (1) QUESTIONNAIRE FOR EACH FAMILY MEMBER			
FAILURE TO ANSWER TRUTHFULLY MAY RESULT IN ADMINISTRATIVE ACTION			
AND/OR RETURN TO CONTINENTAL U.S.			
HAVE YOU EVER? (PLEASE CIRCLE YES OR NO)			
	ENROLLED IN SPECIAL NEEDS PROGRAM/EDUCATION PROBLEMS	YES / NO	
	COUGHED BLOOD	YES / NO	
	FREQUENT TROUBLE SLEEPING	YES / NO	
	FREQUENT OR SEVERE HEADACHE	YES / NO	
	DIZZINESS OR FAINTING SPELLS	YES / NO	
	EYE TROUBLE	YES / NO	
	HEARING LOSS	YES / NO	
	SEVERE TOOTH OR GUM TROUBLE	YES / NO	
	HEAD INJURY	YES / NO	
	PALPITATION OR POUNDING HEART/HEART TROUBLE	YES / NO	
	ASTHMA	YES / NO	
	PAIN OR PRESSURE IN CHEST	YES / NO	
	CHRONIC COUGH	YES / NO	
	bled excessively after injury or tooth extraction	YES / NO	
	MENTAL HEALTH PROBLEMS	YES / NO	
	MARRIAGE/FAMILY COUNSELING	YES / NO	
	IF YOU HAVE A CHILD AGED 11 AND OLDER, HAVE THEY RECEIVED THE MENINGOCOCCAL VACCINE?	YES / NO / N/A	

PATIENT'S IDENTIFICATION (Use this space for Mechanical

RECORDS MAINTAINED AT:	▶		
PATIENT'S NAME (<i>Last, First, Middle Initial</i>)			SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE	
SPONSOR'S NAME		ORGANIZATION	
DEPART/SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH	

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (Rev. 5-84)
 Prescribed by GSA and ICMR
 FIRMR (41 CFR) 201-45.505

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)	
	ATTEMPTED SUICIDE	YES / NO
	DEPRESSION/EXCESSIVE WORRY/NERVOUS TROUBLE OF ANY SORT	YES / NO
	STOMACH, LIVER OR INTESTINAL TROUBLE	YES / NO
	GALL BLADDER TROUBLE OR GALLSTONES	YES/ NO
	NEURALGIC PROBLEMS/EPILEPSY/SEIZURES	YES / NO
	TUMOR, GROWTH, CYST, CANCER	YES / NO
	RUPTURE/HERNIA	YES / NO
	"TRICK" OR LOCKED KNEE	YES / NO
	FREQUENT OR PAINFUL URINATION	YES / NO
	KIDNEY STONE OR BLOOD IN URINE	YES / NO
	ARTHRITIS, RHEUMATISM, OR BURSITIS	YES / NO
	RECURRENT BACK PAIN	YES / NO
	ADVERSE REACTION TO SERUM, DRUG OR MEDICATIONS	YES / NO
	LIST MEDICATIONS YOU TAKE REGULARLY & OR AN "AS NEEDED" BASIS	
	HOSPITALIZATIONS (LIST REASONS BELOW)	YES / NO
	ANY OTHER SIGNIFICAN MEDICAL CONDITIONS NOT MENTIONED ABOVE	YES / NO
**FEMALES:	ARE YOU PREGNANT? HOW MANY WEEKS?	YES / NO
	ANY HISTORY OF OR PRESENT OB / GYN ABNORMALITIES / EXAMS	YES / NO
	<u>EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED.</u> (ATTACH	
	SEPARATE PAGE IF	
	NECESSARY). IF ANY OF THE ABOVE OCCURRED ON THE PAST 3 YEARS, ATTACH A COPY OF	
	MEDICAL RECORDS AND FORWARD TO: USCG SECTOR SAN JUAN, 5 CALLE LA PUNTILLA, SAN JUAN, PR 00901	
	OR FAX ALL FORMS TO 787-289-7991	
	PATIENT/PARENTS SIGNATURE:	
	FOR MEDICAL OFFICER AT USCG SECTOR SAN JUAN ONLY	
	1. REVIEWED OVERSEAS SCREENING FORM	
	(A) CLEARED FOR PCS, (B) NOT CLEARED, (C) ADDITIONAL INFORMATION NEEDED	