

Health Record	CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (<i>Sign each entry</i>)	
	OVERSEAS SCREENING TO PUERTO RICO	
	PLEASE COMPLETE (1) QUESTIONNAIRE FOR THE SPONSOR AND EACH DEPENDANT.	
	FAILURE TO ANSWER TRUTHFULLY MAY RESULT IN ADMINISTRATIVE ACTION	
	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
	HAVE YOU EVER HAD OR THINK YOU NOW HAVE A SUBSTANCE ABUSE OR DRINKING PROBLEM?	YES / NO

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	YES / NO
	ANY HISTORY OF OR PRESENT OB / GYN ABNORMALITIES / EXAMS	YES / NO
	EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED. ATTACH SEPARATE PAGE IF NECESSARY.	
	PLEASE FORWARD A COPY OF ALL MEDICAL RECORDS TO:	
	USCG AIR STATION BORINQUEN ATTN: HS1 MAYA SALAZAR 260 GUARD ROAD AGUADILLA, PR 00603 MAYA.C.SALAZAR@USCG.MIL (787)890-8477	
	PATIENT/PARENTS SIGNATURE :	
	FOR MEDICAL OFFICER AT AIR STATION BORINQUEN ONLY:	
	1. REVIEWED OVERSEAS SCREENING FORM	
	(A) CLEARED FOR PCS, (B) NOT CLEARED, (C) ADDITIONAL INFORMATION NEEDED	