

**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.

**DEERS check completed (HS initial)**

| DATE | SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION <i>(Sign each entry)</i>                        |
|------|---|
|      | <b>Please fill out all highlighted areas to assist us in providing you excellent care. Thank you.</b> |

**Allergies/Reaction:** →  
 None **PCM:**

**Pending Consults:** →  
 None

**Outside Care:** →  
 None

**Past Medical History:**  
 None  
 High Blood pressure  High Cholesterol  Diabetes  Asthma  Overweight  Mental Health  Back/Neck Pain  
 Heart Disease  Heart Attack  Thyroid  Cancer \_\_\_\_\_  
 Other:

**Past Surgical History:**  
 None  Surgeries:

**Family History:**  
 None  
 High Blood pressure  High Cholesterol  Diabetes  Overweight  Mental Health  Thyroid  Heart Disease  
 Cancer \_\_\_\_\_  Other \_\_\_\_\_

**All Current Meds AND Supplements:**  
 None *(Or as listed below, use as many spaces as needed to fill in medications)*

| Medication Name ↓         | Dose ↓ | How often taken? ↓ | Last taken? ↓ |
|---------------------------|--------|--------------------|---------------|
| <b>Tobacco Use:</b> Y / N |        |                    |               |
| <b>PPD:</b>               |        |                    |               |
| <b>Alcohol use:</b> Y / N |        |                    |               |
|                           |        |                    |               |
|                           |        |                    |               |
|                           |        |                    |               |
|                           |        |                    |               |
|                           |        |                    |               |
|                           |        |                    |               |
|                           |        |                    |               |

This medication history is complete to the best of my knowledge. **Please sign:**

|                              |                  |                    |                       |
|------------------------------|------------------|--------------------|-----------------------|
| HOSPITAL OR MEDICAL FACILITY | STATUS/RATE/RANK | DEPARTMENT/SERVICE | RECORDS MAINTAINED AT |
|------------------------------|------------------|--------------------|-----------------------|

|                |                      |                         |
|----------------|----------------------|-------------------------|
| SPONSOR'S NAME | FULL SOCIAL SECURITY | RELATIONSHIP TO SPONSOR |
|----------------|----------------------|-------------------------|

|  |                     |             |
|--|---------------------|-------------|
| PATIENT'S IDENTIFICATION: <i>(For typed or written entries, give: Name - last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)</i> | DATE OF BIRTH / AGE | WARD NUMBER |
|--|---------------------|-------------|

**Current Address:** \_\_\_\_\_  
**City/State/Zip:** \_\_\_\_\_  
**Personal Phone:** \_\_\_\_\_  
**Work Phone:** \_\_\_\_\_

**CHRONOLOGICAL RECORD OF MEDICAL CARE**  
 Medical Record  
**STANDARD FORM 600** (REV. 1/2016)  
 Prescribed by GSA/ICMR  
 FIRMR (41 CFR) 201-9.202-1

**Do you have an advanced directive? Yes / No**  
**If no: Would you like assistance in creating one? Yes / No**  
**If yes: Referred to Legal: Yes / No**

|                                       |   |                               |                 |                |
|---------------------------------------|---|-------------------------------|-----------------|----------------|
| DATE                                  | Provider and Pharmacy Sections (Not filled out by patients)   |                               |                 |                |
| <b>Medications:<br/>(New/Refills)</b> | <b>Medication Name</b>  | <b>Dose/ Route/ Frequency</b> | <b>Quantity</b> | <b>Refills</b> |
| <input type="checkbox"/> None         |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
| <b>Medical Officer:</b> _____         |   |                               |                 |                |
| <b>Pharmacy Notes:</b>                | <input type="checkbox"/> <b>Current and new medications, supplements, and herbals have been assessed for safety and pharmacotherapeutic appropriateness. (Only if medications are dispensed or patient requests.)</b> |                               |                 |                |
|                                       |   |                               |                 |                |
| <b>Pharmacist Signature:</b>          |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |
|                                       |   |                               |                 |                |