

Health Record		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	OVERSEAS SCREENING TO PUERTO RICO		
	PLEASE COMPLETE QUESTIONNAIRE FOR THE SPONSOR AND EACH DEPENDANT. FAILURE TO ANSWER TRUTHFULLY MAY RESULT IN ADMINISTRATIVE ACTION.		
	HAVE YOU EVER? (PLEASE CIRCLE YES OR NO)		
	ARE YOU TRANSFERING TO ST THOMAS / ST CROIX	YES / 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	
	HAVE YOU EVER BEEN AFFECTED BY A TRAMATIC EVENT? (INJURY, ASSAULT, DEATH)	YES / NO	
	HAVE YOU EVER HAD OR THINK YOU NOW HAVE A SUBSTANCE ABUSE OR DRINKING PROBLEM?	YES / NO	
	RECEIVED COUNSELING OF ANY TYPE	YES / NO	

PATIENT'S IDENTIFICATION (Use this space for Mechanical

RECORDS MAINTAINED AT:			
PATIENT'S NAME (Last, First, Middle Initial)			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 (<i>Sign each entry</i>)	
	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 SIGNIFICANT MEDICAL CONDITIONS NOT MENTIONED ABOVE	YES / NO
**FEMALES:	ARE YOU PREGNANT	YES / NO
**FEMALES:	ANY HISTORY OF OR PRESENT OB / GYN ABNORMALITIES / EXAMS	YES / NO
**FEMALES:	ARE YOU AWARE OF THE MOSQUITO BORNE ILLNESSES IN THE CARIBBEAN AND THEIR POTENTIAL ADVERSE EFFECTS ON PREGNANCIES	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 SECTOR SAN JUAN ATTN: HS1 JUAN ZAVALA JUAN.A.ZAVALA@USCG.MIL 5 CALLE LA PUNTILLA SAN JUAN, PR 00901 Tele: (787)729-2305 Fax: (787)729-2336	PT MEDS
	PATIENT/PARENTS SIGNATURE :	
	FOR MEDICAL OFFICER OR PHYSICIAN ONLY:	
	1. REVIEWED OVERSEAS SCREENING FORM	
	(A) CLEARED FOR PCS, (B) NOT CLEARED, (C) ADDITIONAL INFORMATION NEEDED	