FILE FOLDER
FRAGO 148

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATING ORGANIZATION (Sign each entry)
	PRE-TRANSFER MEDICAL ASSESSMENT
	**LIST ANY YES RESPONSES IN RAMARKS SECTION ON REVERSE SIDE OF FORM
	AGE:_____

	(Y) (N)	(Y) (N)
	( ) ( ) Allergies	( ) ( ) Recent illness/injury
	( ) ( ) Dental Problems	( ) ( ) History of psychological problems (Date)
	( ) ( ) HIV positive	( ) ( ) Chronic health problems or infectious diseases
	( ) ( ) Previous Suicide Attempts (Date)	( ) ( ) Females only; Are you pregnant?
	( ) ( ) History of alcohol abuse/treatment (Date)	( ) ( ) Current medications
	( ) ( ) Current physical complaint(s)	1.
	1. Cough/Sputum Production	2.
	2. Rash	3.
	3. Diarrhea/Vomiting	
	4. Night sweats	
	5. Pain	
	6. Exposure to TB	
	7. Lice/Other infestation	
	8. Contagious disease in the past 12 months?	
	8. Other:	
*****	FOR MEDICAL PERSONNEL USE ONLY DETAINEE'S INITIALS (_____)	
	HIV/TUBERCULOSIS QU ESTIONAIRE	
	Do you have a history or, or do you presently have any of the following symptoms or conditions:	

	(Y) (N)	(Y) (N)
	( ) ( ) Persistent cough/shortness of breath	( ) ( ) Cough with blood and/or dry cough
	( ) ( ) Unexplained weight loss/diarrhea X 2 weeks	( ) ( ) Unexplained persistent fever
	( ) ( ) Night Sweats	( ) ( ) Swollen glands/lymph nodes
	( ) ( ) Prolonged fatigue or run -down feeling	( ) ( ) Loss of appetite and or whit e patches in mouth
	( ) ( ) Recent exposure to someone with TB	( ) ( ) Past abnormal X -Ray (Date)
	( ) ( ) Hepatitis B series completed	( ) ( ) Previous TB infection or treatment
	( ) ( ) Stomach surgery, Kidney failu re, Blood disorders	
	( ) ( ) Scars, birthmarks, tattoos:	
	1.	4.
	2.	5.
	3.	6.

PATIENT'S IDENTIFICATION (Use this space for Mechanical imprint)	RECORDS MAINTAINED > AT:		
	PATIENT'S NAME (Last, First, Middle Initial)		SEX
	RELATIONSHIP TO SPONSOR ----------	STATUS DETAINEE	RANK/GRADE
	SPONSOR'S NAME ----------	ORGANIZATION	
	DEPART/SERVICE	SSN/IDENTIFICATION NO.	DOB

780

734

DOD-045990

DATE	SYMPTOMS, DIAGNOSIS, TREATING ORGANIZATION (Sign each entry)
	----------BELOW PORTION TO BE COMPLETED BY MEDICAL STAFF----------
	PHYSICAL APPEARANCE
	Clean, well groomed (Y) (N) — Tremors, sweating (Y) (N)
	Rashes, needle marks (Y) (N) — Exposure to tuberculosis (Y) (N)
	Body deformities (Y) (N) — Infestations (Y) (N)
	Cuts, bruises, lesions (Y) (N) — Confinement Phys. Date:_____
	VITAL SIGNS: Weight: Height: Temp: B/P: Pulse: Resp:
	PPD given: HIV drawn: RPR drawn:
	Physical Exam: Within normal limits (Y) (N) — See remarks for any (N) answers
	Head ( ) ( )
	Lungs/Chest ( ) ( ) — LAB (If available)
	Back ( ) ( ) — CBC:
	Heart ( ) ( ) — U/A:
	Extremities ( ) ( ) — Chest X-Ray:
	MENTAL STATUS
	(Y) (N)
	( ) ( ) Alert, well oriented
	( ) ( ) Long and short term memory intact
	( ) ( ) Experiencing hallucinations, delusions, or feelings of paranoia
	( ) ( ) Calm, cooperative
	DISPOSITION
	(Y) (N) — Prescriptions:
	( ) ( ) **Cleared** for basic transfer procedures
	( ) ( ) **Cleared** for litter transfer procedures
	( ) ( ) **NOT** medically cleared for transfer _____(days/weeks)
	Recommended type of confinement ( ) Normal ( ) Solitary ( ) Other -explain:
	I do not have any SUICIDAL and or HOMICIDAL feelings at this time. If I develop any such ideas or plans, I will notify a staff member before acting on such feelings or ideas. (SIG.)_____
	Date/Time information transmitted to component surgeon's office
	Infection Control recommendations
	( ) Standard Precautions
	( ) Contact/Droplet Precautions
	( ) Airborne Precautions
	SCREENER
	MEDICAL STAFF SIGNATURE
	SCREENER
	MEDICAL STAFF SIGNATURE