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

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