

MEDICAL RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS DIAGNOSIS TREATMENT TREATING ORGANIZATION (Sign each entry)

CAMP GEIGER BRANCH MEDICAL CLINIC
NAVAL HOSPITAL CAMP LEJEUNE, NORTH CAROLINA

The medical staff at Camp Geiger is committed to providing you with the best health care available. Your 100% honesty in answering the below questions is very important. If more privacy is needed for your interview, please notify the interviewing health care provider.

1. Do you wear glasses? YES or NO Where you issued glasses in boot camp? YES or NO
 If issued glasses are they damaged? YES or NO

CONTACT LENSES ARE NOT ALLOWED DURING TRAINING AT SOI.

2. Have you been treated at a medical or dental facility for any reason during your training at Parris Island or during boot leave?
 YES or NO

a. If you answered "YES", please indicate what you were treated for:

3. I understand that if I experience feelings of suicide, overwhelming anxiety, despair, depression, or the desire to harm myself and/others, I will immediately contact my supervisor, a chaplain, and/or any medical personnel. I certify that I not experiencing any of the above emotions at this time.

Students Initials: _____

4. FOR FEMALE STUDENTS ONLY

a. Have you ever had an abnormal PAP smear? YES or NO. If "Yes", please indicate when and why if possible:

b. Are you currently on birth control? YES or NO If yes do you require a refill? YES or NO

c. Could there be a possibility that you may be pregnant at this time? YES or NO

Student's Signature: _____

Date: _____

TO BE FILLED OUT BY HEALTH CARE PROVIDER

G6PD: Normal / Deficient Sickle Cell: Positive / Negative Date of last HIV: _____

Date of last Tetanus: _____ Date of last PPD: _____

If Converter is member on INH? YES or NO. Needs Refill? YES or NO

PMH- Heat injuries YES or NO Cellulitis YES or NO Musculoskeletal YES or NO

If YES where? _____

If YES where? _____

If YES where? _____

Date of last complete Physical Examination: _____

Medical Record review and Screening results in NO disqualifying issues. FIT TO TRAIN.

Medical discrepancy noted, see comments on back of form. and referral/treatment plan.

PRINT HEALTH CARE PROVIDER NAME

SIGNATURE

DATE

HOSPITAL OF MEDICAL CLINIC

STATUS

DEPART./SERVICE

RECORDS MAINTAINED AT

SPONSOR'S NAME

SSN/ID NO.

RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name-last, first, middle; ID No or SSN; Sex Date of Birth; Rank/Grade.)

REGISTER NO.

WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE

Medical Record

STANDARD FORM 1000 (REV. 1-87)

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(CONT.)

CONSULT FROM IN-POST

TO: Primary Care Manager Blue Division Gold Division Geiger Branch Clinic

Comments: _____

DATE	MEMBER NEEDS TO GO TO THE BRANCH MEDICAL CLINIC CAMP GEIGER FOR FOLLOW UP DECREPANCIES
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_____ Missing physical examination _____ Needs glasses ordered

_____ Missing shot record _____ Needs Immunization

_____ Need pregnancy test _____ Needs birth control refill

_____ Needs to see provider / follow up appointment

Member signature _____ Date _____ Interviewer signature _____

MEDICAL STAFF USE ONLY

Fit to train

Do not drop to train patient needs follow up

Glasses ordered on _____ Time _____

Immunization given

Pregnancy test results

Received fax of physical examination / shot record

Provider Signature _____ Date _____