MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Are you sick today? Yes ____, No ____, Don't Know ____
	Do you have a fever today? Yes ____, No ____, Don't Know ____
	Do you have allergies? (Eggs, Thimerosol, Neomycin, gelatin, Rubber/latex, medications, preservatives, other? Yes ____, No ____, Don't know ____.
	Do you have a history of adverse events after any vaccine? Yes ____, No ____, Don't Know ____.
	Do you take a blood thinner like Coumadin or have a bleeding problem? Yes ____, No ____, Don't Know ___?
	Do you have a chronic Illness (heart, lung, liver, Kidney, skin disease, diabetes, sickle cell, splenectomy, frequent infections?) Yes ____, No ____, Don't Know ____?
	Do you have cancer, leukemia, HIV/AIDS, transplant, any other immune problems? Chronic skin disease like eczema, atopic dermatitis? Yes ____ No ____, Don't Know _____?
	Have you taken cortisone, prednisone,other steroids, anticancer drugs, or x-ray treatment in the past 3 months? Yes ____, No ____, Don't Know ____
	Have you received a transfusion of blood or plasma, or been given a medicine called immune (gamma) globulin in the past year? Yes ____, No ____, Don't Know ____.
	Could you be pregnant? Yes ____, No ____, Don't Know ____. When was your last menstrual period? Day ____ Month ____ Year ____.
	Is there a chance you could become pregnant in the next month? Yes ____, No ____, Don't Know ____.
	Have you received any vaccinations in the last 4 weeks? Yes ____, No ____, Don't Know ____. Check MMR__, Measles__, Mumps__, Rubella__, Varicella/Chickenpox__, Yellow Fever__, Smallpox__,
	Have you had a seizure, brain or psychiatric problem?
	Are you here today to receive the next shot in a series? Yes ___, No ____. If yes, which series? Anthrax__, Hepatitis A__, Hepatitis B__, JEV__, Rabies__, Other _____.
	Are you traveling abroad soon? Yes ____, No _____ Departure Date _____ Countries _____
	Patient Signature _____ Date
	Providers Comments: Cleared for Immunization _____, Not Cleared for Immunization ____

HOSPITAL OR MEDICAL FACILITY	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 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*