

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 REMARKS SECTION ON REVERSE SIDE OF FORM			
AGE: _____			
(Y) (N)	(Y) (N)	(Y) (N)	(Y) (N)
() () Allergies	() () Recent illness/injury	() () History of psychological problems (Date)	() () Chronic health problems or infectious diseases
() () Dental Problems	() () Females only; Are you pregnant?	() () Current medications	
() () HIV positive			
() () Previous Suicide Attempts (Date)			
() () History of alcohol abuse/treatment (Date)			
() () 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 QUESTIONNAIRE			
Do you have a history or, or do you presently have any of the following symptoms or conditions:			
(Y) (N)	(Y) (N)	(Y) (N)	(Y) (N)
() () Persistent cough/shortness of breath	() () Cough with blood and/or dry cough	() () Unexplained persistent fever	() () Swollen glands/lymph nodes
() () Unexplained weight loss/diarrhea X 2 weeks	() () Loss of appetite and or white patches in mouth	() () Past abnormal X-Ray (Date)	() () Previous TB infection or treatment
() () Night Sweats	() () Stomach surgery, Kidney failure, Blood disorders		
() () Prolonged fatigue or run-down feeling	() () Scars, birthmarks, tattoos:		
() () Recent exposure to someone with TB	1.	4.	
() () Hepatitis B series completed	2.	5.	
() () Stomach surgery, Kidney failure, Blood disorders	3.	6.	
() () Scars, birthmarks, tattoos:			
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

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					

184