AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	TUBERCULOSIS AND LEAD EXPOSURE SCREENING FORM
	Tuberculosis:
	1. Has your child lived or traveled outside the United States? **YES NO**
	Please circle area(s): Africa, Asia, Latin America, Eastern Europe, Other
	2. Has anyone in your household had active tuberculosis? **YES NO**
	3. Has anyone in your household had a positive tuberculosis skin test? **YES NO**
	4. Does your child routinely visit any of the following institutions: homeless shelter, nursing home,
	correctional facility (prison), or group home? **YES NO**
	Lead Exposure: THESE QUESTIONS ARE INTENDED ONLY FOR CHILDREN 6 MONTHS THROUGH 6 YEARS OF AGE.
	1. Does your child live in a house that was built before 1950? **Yes No Don't Know**
	2. Live in or regularly visit a house, daycare center, or preschool that was built before 1980 which has peeling or
	chipping paint, or is undergoing renovation or remodeling? **Yes No Don't Know**
	3. Have a sibling, housemate, or playmate who has had an elevated lead level? **Yes No Don't Know**
	4. Live or spend time with someone whose job or hobbies involve exposure to lead? (Example: Reloads ammunition,
	makes fishing weights, makes ceramics, makes stained glass, works at a firing range, works with industrial or shipboard
	paint removal, works with electrical or torch soldering, makes soft metal castings.) **Yes No Don't Know**
	5. Live or spend time near any location that you think might release lead (lead smelter,
	radiator shop, battery recycler, etc.)? **Yes No Don't Know**
	6. Live in or regularly visit a house, day care unit, or preschool that was identified by a DOD inspection team as a
	major risk for lead? **Yes No Don't Know**
	Provider Section: I have reviewed the above risk factors and recommend the following tests:
	None CBC PPD Lead level
	Provider signature: _____ Date: _____

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
NHCL Annapolis			
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.

NAME: _____

FMP/SSN: _____

DOB: _____

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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