AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	ACUTE GASTROENTERITIS
S:	_____ year old _____with a _____day history of: (circle + response, cross out negatives)
Allergies:	Nausea vomiting: last episode_____ diarrhea: # of stools in last 12 hours _____
	Abdominal pain fever blood in stools lightheadedness when standing
Meds:	Additional History:
	Yes / No Have you received antibiotics in past month. If yes, NAME _____ Yes / No Foreign travel in past month. If yes, COUNTRY _____
	Yes / No If female, could you be pregnant? First day of last menses _____ Yes / No Able to drink and keep down any fluids
	Yes / No Eaten raw seafood recently or drank any untreated water? (streams, lakes, etc….) Yes / No Decreased urination frequency LESS than every 8 hours?
	Yes / No Other people sick who ate with you recently? If yes, WHO? _____
O:	(Flat) BP _____ HR _____ Temp _____ Wt _____ (Upright) BP _____ HR _____ RR _____
Labs:	**General:** NAD Abnl- **Mucus Membranes:** Moist Tacky/ Dry
	HEENT: Benign Abnl- **Neck:** Benign Abnl-
	Lungs: CTA bilat Abnl- **CV:** RR no M Abnl-
	Abdomen: soft NABS Abnl- Nontender Tender-
	Other Exam:
	IVF – [ ] NS [ ] LR – one litre bolus; Repeat BP _____ HR _____ [ ] Yes [ ] No – Pt feels improved and safe for d/c home after treatment
A:	**AGE** or OTHER:
P:	Literature on disease process and follow up given; Push PO fluids; Wash hands freq.; Med SE (if needed) d/w pt [ ] Stool Cx [ ] CBC w/ diff [ ] Occult blood [ ] Stool O & P [ ] Norovirus
	[ ] Sick in Quarters for _____ day(s) [ ] Light duty for _____days, [ ] Phenergan 25 mg tabs/supp by mouth every 6 hours as needed – sedating! # _____ RF _____
	[ ] Loperamide 2 mg – take 2 tabs po now then one tab prn after each loose stool up to 8/dy # _____ RF_____ [ ] Azithromycin 250mg by mouth, take 1 a day for three days # _____ RF _____
	[ ] Ciprofloxacin 500mg by mouth, take 1 a day for three days #_____ RF _____ [ ] Submit medical event report via NDRSi

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

NAME **SEX**

STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR

FMP/SSN **RANK**

FIRMR (41 CFR) 201-9.202-1 USAPA V2.00

DOB **PHONE**