

| DATE | SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION <i>(Sign each entry)</i> |
|------|---|
| | PATIENT INTERVIEW |
| | 1. ARE THERE ANY RELIGIOUS BARRIERS TO CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | 2. ARE THERE ANY CULTURAL BARRIERS TO CARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF "YES" PLEASE EXPLAIN BRIEFLY: |
| | 3. ARE YOU ON FLIGHT STATUS? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES SEND TO AVR FOR ADMIN "UP CHIT" |
| | HEALTH RECORD REVIEW |
| | ❖ IMMUNIZATION CURRENT: <input type="checkbox"/> YES <input type="checkbox"/> NO NEEDS: <input type="checkbox"/> YELLOW FEVER dt: _____ <input type="checkbox"/> TYPHOID dt: _____ <input type="checkbox"/> TETANUS dt: _____ <input type="checkbox"/> OPV dt: _____ <input type="checkbox"/> MMR dt: _____ <input type="checkbox"/> HEP A dt: #1 _____ #2 _____ <input type="checkbox"/> PPD dt: _____ results _____ |
| | <input type="checkbox"/> JEV dt: #1 _____ #2 _____ #3 _____ ❖ LAST PHYSICAL EXAM dt: _____ (FEMALE ONLY) LAST PAP EXAM dt: _____ |
| | (MALE ONLY) LAST PROSTATE EXAM dt: _____ PSA: _____ MAMMOGRAM dt: _____ <small>(MALE AGE ^ 40) (BASELINE AGE 35 - 40 / 40 - 50 EVERY YR 0</small> |
| | ❖ ABO/RH DOCUMENTED: <input type="checkbox"/> YES <input type="checkbox"/> NO RESULTS : _____ G6PD DEFICIENT: <input type="checkbox"/> YES <input type="checkbox"/> NO RESULTS: _____ ❖ HIV DATE: _____ SICKLE CELL: <input type="checkbox"/> YES <input type="checkbox"/> NO RESULTS: |
| | ❖ DNA DRAWN dt: _____ IN DEERS : <input type="checkbox"/> YES <input type="checkbox"/> NO ❖ ALLERGIES: _____ MED RED TAGS ISSUED: <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | ❖ DD2215: <input type="checkbox"/> YES <input type="checkbox"/> NO dt: _____ HEARING CON PROM: <input type="checkbox"/> YES <input type="checkbox"/> NO LAST DD2216 dt: _____ ❖ EYE EXAM dt: _____ EYE WEAR / GAS MASK INSERT ISSUE: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A |
| | ❖ PPD CONVERTER: <input type="checkbox"/> YES <input type="checkbox"/> NO INH TREATMENT COMPLETED: <input type="checkbox"/> YES <input type="checkbox"/> NO ❖ ANNUAL PATIENT TB QUESTIONNAIRE: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A dt: _____ |
| | ❖ PRIVACY ACT STATEMENT SIGN: <input type="checkbox"/> YES <input type="checkbox"/> NO ❖ PENCIL ENTRY <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | ❖ ABSTRACT OF SERVICE & MEDICAL HISTORY (NAV MED 1406) UPDATED: <input type="checkbox"/> YES <input type="checkbox"/> NO ❖ MEDICAL SURVEILLANCE QUESTIONNAIRE UPDATED (OPNAV 5100/15): <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | ❖ REMARKS: |
| | HEALTH PROMOTION REFERRALS / INTERVENTIONS INDICATED |
| | <input type="checkbox"/> HEAR survey completed and reviewed with patient. Health intervention recommended by HEAR: |
| | 1. |
| | 2. |
| | 3. |
| | <input type="checkbox"/> PCM <input type="checkbox"/> HEARING CONSERVATION <input type="checkbox"/> HEALTH PROMOTIONS/NUTRITION COUNSELLING <input type="checkbox"/> CHAPLAIN <input type="checkbox"/> SEMPER FIT COUNSELOR <input type="checkbox"/> HEALTH PROMOTIONS/CHOLESTEROL CLINIC |
| | <input type="checkbox"/> DAPA <input type="checkbox"/> PREVENTIVE MEDICINE <input type="checkbox"/> HEALTH PROMOTIONS/ TOBACCO CESSATION <input type="checkbox"/> OTHER |
| | 1. Patient given a \$ _____ appt with _____, @ _____ HRS on _____ 2. Patient given a \$ _____ appt with _____, @ _____ HRS on _____ |
| | PATIENT CHECK-IN COMPLETION POINTS |
| | Given a copy of the Clinic Policies and Guidelines. CHCS Full-Reg/Allergies/Donor updated. |
| | Local Environmental Hazards reviewed. TRICARE Enrollment / Transfer form completed |
| | DD FORM 2766, Adult Preventive and Chronic Care Flow Sheet , SECTIONS 1, 2, 3, 4, 5, 6 7, completed |
| | STAFF MEMBERS SIGNATURE _____ PCM SIGNATURE (IF HEAR SURVY IS GREATER THAN LEVEL ONE) |
| | _____ SAMS UPDATED DATE SIGNATURE |