NSN 7540-00-634-4176

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

Date:

ANTHRAX EXPOSURE ENCOUNTER

S: Patient directly / indirectly (circle one) exposed to presumed anthrax

Patient currently has the following symptoms: ❑ None/No complaints

Medical History:

1. ❑ Burning/watery eyes ❑ Runny Nose ❑ Nausea
2. ❑ Burning nose/throat/mouth ❑ Sore Throat ❑ Vomiting
3. ❑ Headache ❑ Cough ❑ Diarrhea

❑ Fatigue/Maliase ❑ Phlegm ❑ Abdominal Pain

Medications:

❑ Fever/Chills/Sweats ❑ Chest Pain ❑ Chest Pain

1. ❑ Muscle Aches ❑ Shortness of Breath ❑ Other:
2. O:
3.
4.

A: Presumed anthrax exposure per positive environmental sample

Other special considerations: ❑ Immunocompromised ❑ First Responder
❑ Pregnant ❑ Breast Feeding
❑ Child (age): _____ Weight: _____
❑ Medication Allergy: _____

P:
❑ Reassure patient
❑ Patient Education Handout given
❑ Instructions given to seek care if symptoms develop
❑ Instructions given to inform providers of this incident when seeking care in the next 3 months.
❑ Rx given: ❑ Ciprofloxacin 500mg po BID #14 ❑ Doxycycline 100mg po BID #14
❑ Ciprofloxacin 10-15 mg/kg po BID _____
❑ Patient to be contacted days 7, 15, 30, 67 for follow up.
❑ Contact information given for Internal Medicine dept/provider.

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.

Patient's Name:

Sponsor's SSN:

Home Phone: Email:

Work Phone:

Primary Physician:

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

Revised 12 Dec 01

USNH Okinawa

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