

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION <i>(Sign each entry)</i>
	ANNUAL PPD CONVERTER EXAM
	1. DATE OF PPD REACTION: SIZE:
	2. INH COMPLETION DATE: MONTHS TREATED:
	3. RECENT TREATMENT OR ILLNESSES? IF YES, PLEASE EXPLAIN BELOW:
	4. SINCE THE LAST EXAM, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING:
	a. Dark Urine or Abnormal Stool? b. Yellow Skin?
	c. Persistent Coughing for more than 2 weeks? d. Bloody Sputum?
	e. Nausea, vomiting, diarrhea lasting over 3 days? f. Weakness?
	g. Abnormal muscle or joint pains? h. Unexplained fever?
	i. Unexplained weight changes? j. Night Sweats?
	k. Burning or tingling in the hands or feet?
	5. IF ANY OF THE ABOVE IS YES, PLEASE EXPLAIN:
	6. CHEST X-RAY: EXAM NOTES:
	7. PLAN: Return to Medical on for next Annual PPD Exam
	HM SIGNATURE: MO SIGNATURE:

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*

RECORDS MAINTAINED AT:		
PATIENT'S NAME <i>(Last, First, Middle Initial)</i>		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE
SPONSOR'S NAME		ORGANIZATION
DEPART./SERVICE	SSN/IDENTIFICATION NO.	DATE OF BIRTH

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

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