HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	
	1.What is the reason for today's visit:
	2. Have you been able to do anything to improve this issue?
	3. How long have you had this issue?
	4. Is this issue getting better or worse?
	5. Please list any allergies (drug, latex, food) you have?
	6. Please list the medications that you take:
	7. Please list any chronic medical problems that you have:
	8. Please list any past surgeries:
	9. Please list any medical conditions that run in your family:
	Yes ☐ No ☐ Is this visit deployment related?
	Yes ☐ No ☐ Do you have any learning disabilities? If yes, please list:
	Yes ☐ No ☐ Are you taking any vitamins, herbals, over the counter medications or dietary supplements?
	If yes, please list:
	Yes ☐ No ☐ Do you use tobacco products? If yes, then what kind_____ Interested in quitting? Yes ☐ No ☐
	Yes ☐ No ☐ Do you drink alcohol? **If you consume alcohol, please answer questions below:**
	What kind? _____ How often? _____
	Yes ☐ No ☐ Have you ever attempted to cutback? Does your drinking make anyone angry? Yes ☐ No ☐
	Yes ☐ No ☐ Do you feel guilty about your drinking? Do you ever have an "eye-opener?" Yes ☐ No ☐
	CONTINUE ON BACK

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

RECORDS MAINTAINED AT:		
PATIENT'S NAME ***(Last, First, Middle initial)***		**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)*
	ROS:
	Yes ☐ No ☐ Have you recently lost weight? If so, were you trying to lose weight? Yes ☐ No ☐
	Please rate your pain 0 1 2 3 4 5 6 7 8 9 10
	now: *Pain Free* *Mild* *Moderate* *Severe* *Totally Disabling*
	Yes ☐ No ☐ Do you have depression or feel depressed?
	If yes, are you taking medication for depression? Yes ☐ No ☐
	If yes, are you having any thoughts of hurting yourself or ending your life? Yes ☐ No ☐
	BELOW FOR STAFF USE ONLY ☐ ***Reviewed note and agree with above ____ (provider initials)***
	VITALS: B/P _____ Pulse _____ RR _____ Temp _____
	Ht _____ Wt _____ O_2Sat _____
	SUBJECTIVE:
	OBJECTIVE:
	ASSESSMENT:
	PLAN:

☐ AHLTA was not accessible during this patient visit.