(See DD Form 2005 for Privacy Act Statement)

MEDICAL RECORD -- SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-400; the proponent agency is the Office of the Surgeon General.

REPORT TITLE

PERIODIC OCCUPATIONAL HEALTH HISTORY

OTSG APPROVED *(Date)*

PART I - ADMINISTRATIVE DATA

1. Purpose of visit	2. Age	3. Sex	4. Race
☐ New hire ☐ Medical surveillance ☐ Pre-employment ☐ Termination		☐ Male ☐ Female	

5. Occupational code	6. Job title	7. Organization and station

PART II - SOAP

S:

8. Work Hx:

9. Medical Hx:

a. Surgery:

b. Fx:

c. Allergies:

d. Current medication:

e. OTC, herbal and dietary supplements:

f.1. Currently experiencing pain? ☐ Yes ☐ No | f.2. If "Yes," where? | f.3. Current pain level (0-10):

g.1. Does pain interfere with normal functions and activities? ☐ Yes ☐ No | g.2. If "Yes," explain:

h. Pain management:

i. Latex questionnaire: | j. Latex allergy? ☐ Yes ☐ No

k. Nutrition assessment:

l. Alcohol usage: | m. Smoking Hx: | n. Hobbies:

o. Potential work exposures and hazards:

p. Safety equipment:

(Continue on reverse)

PREPARED BY *(Signature & Title)*	DEPARTMENT/SERVICE/CLINIC	DATE

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)*

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

O:

10. Ht: in.	11. Wt: lbs.	12. BP:	13. Pulse:

14. Physical exam (if necessary):

15. Immunization review (if necessary):
- ☐ Hep B #1
- ☐ Hep B #2
- ☐ Hep B #3
- ☐ VZ
- ☐ PPD
- ☐ Chest x-ray (if indicated)
- ☐ T/D
- ☐ Polio

A:

16. General health status: ☐ Good ☐ Fair ☐ Poor

P:

17. Screening tests: *(Select all that apply.)* ☐ Hearing ☐ Vision ☐ EKG ☐ PFT ☐ Chest x-ray ☐ PPD

18. Lab tests: *(Select all that apply.)* ☐ CBC ☐ BUN ☐ Creatinine ☐ LFT ☐ Lead ☐ Cholinesterase ☐ Mumps titre ☐ Rubella titre ☐ VZ titre ☐ Hep B titre

19. Health education and teaching:

20. Consultation and or referral (if necessary):

21. Disposition (to include return visit, if necessary):

22a.Provider's printed name or stamp	22b.Provider's signature	22c.Date

PART III - FOLLOW UP

23. Review of test results:

24. Tests repeated (if necessary):

25. Health education and counseling:

26. Employee was referred to his or her primary care provider with copies of medical surveillance results: ☐ Yes ☐ No

27a. Employee was notified of the medical surveillance results: ☐ Yes ☐ No | 27b. Date notified:

28. Employee was referred to- ☐ Preventive Medicine Service ☐ Industrial Hygiene ☐ Installation Safety Office ☐ Supervisor

29. Comments:

22a.Provider's printed name or stamp	22b.Provider's signature	22c.Date