AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	Lying BP: Pulse: Sitting BP: Pulse: Standing BP: Pulse:
Check-in time:	Temperature: Respiration: Height: Weight: Age:
Time seen:	Allergies to medications:
Time released:	Prescribed medications:
	Over-the-counter medications:
	Herbal: Dietary:
	Reason for visit:
	Pain Scale: ___/10 ☐ Past ☐ Current Location:
	Visit is related to: ☐ Deployment V70.5 __ __ 6 ☐ Terrorism ☐ Bio-weapons
	Is this the first visit since being redeployed? ☐ Yes ☐ No
	Refer to:
	Nurse's or techs signature:

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.

Last name: _____ First name: _____ MI: _____

Rank: _____ SSN: _____

Unit: _____

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (Rev. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202.1
MEDDAC (Ft Meade) OP 390, 1 Feb 03
Previous editions are obsolete.