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

Date_____
Time_____
HCP_____
T_____ P_____
BP____ R____
Wt_____
Tob Y/N
ppd___yrs___
PRP Y/N
All_____
_____
Med

Family Practice Clinic **31 MDG** **Aviano AB, Italy**

S: _____ y/o male/female c/o **UPPER RESPIRATORY SYMPTOMS** for _____ days.

Yes/No Temp >100.0F or above
Yes/No Thick, discolored nasal discharge
Yes/No Clear watery nasal discharge
Yes/No Pain over sinus areas and upper teeth
Yes/No Body aches
Yes/No Pain worsens with bending over
Yes/No Headache
Yes/No Post nasal drip
Yes/No Dry Cough
Yes/No Sore throat
Yes/No Productive with ___phlegm
Yes/No Tender, swollen lymph nodes
Yes/No SOB
Yes/No Severe difficulty in swallowing
Yes/No Itchy eyes, nose, or throat
Yes/No Ear pain
Yes/No Sneezing
Yes/No Ear discharge

PMH: Yes/No Allergy problems
Yes/No Sinus problems
Yes/No Asthma

O: General:
Head: nontender tender
Ears: **Canals:** clear cerumen discharge red
TMs: intact shiny red dull perforated fluid level
Nose: edematous clear **Mucosa:** pale boggy benign red discharge: clear purulent
Throat: benign red edematous pus tonsillar size: _/4 symmetric
Neck: Lymphadenopathy anterior posterior cervical
Lungs: CTA rales rhonchi inspiratory expiratory
X-ray/Labs-

A: URI Sinusitis Bronchitis Allergic Rhinitis Other_____

P:

P:

ATIENT'S IDENTIFICATION *(Use this space for Mechanical nprint)*

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)*