

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION <i>(Sign each entry)</i>
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NMCLPH Preventive Health Assessment for Population Health Improvement

Sex: M F	I may be reached by: Telephone - Work () Home: ()
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AGE:	Email Address:
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Ht:	If Yes, List specific relative.
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Wt:	1. Do you or your blood relative(s) have high blood sugar or diabetes?
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BP:	NO YES(myself) YES(blood relative)
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P:	2. Do you or your family members have a history of high blood pressure?
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R:	NO YES(myself) YES(blood relative)
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Temp:	3. Do you or your family members have a history of cancer?
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Tobacco:	NO YES(myself) YES(blood relative)
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ETOH:	4. Exercise minimum of 30 mins. 3 days a week? YES NO
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Occupation:	5. Occupational Risk and Surveillance Required? YES NO
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If Yes, List:

List Meds,	6. Medically Ready for Deployment: YES NO ?
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include OTC/Herbs:	7. Have you had: Tetanus shot in the last 10 years? YES NO ?
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	Flu shot this year? YES NO ?
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	Are all immunizations current? YES NO ?
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	8. Have you had a cholesterol test in the last 5 years? YES NO ?
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	Last Cholesterol result: HDL: LDL: TRIG: Total CHOL:
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Name of PCM and Clinic that provides your Primary Care:

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
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SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR
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PATIENT'S IDENTIFICATION: <i>(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)</i>	REGISTER NO.	WARD NO.
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