

MEDICAL RECORD--SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of the Surgeon General.

REPORT TITLE INTERVAL MEDICAL AND OCCUPATIONAL HISTORY FOR CHEMICAL AGENT WORKERS	OTSG APPROVED (Date) (YYYYMMDD)
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INSTRUCTIONS: Answer each question by checking the appropriate box. Explain all "Yes" answers on the back of the form.

	Yes	No	Unsure
1. Since your last exam on _____ (Clinic staff enter date of last exam.)			
a. Have you had any changes in your health?			
b. Have you been prescribed any new medications?			
c. Have any previous medications been changed or discontinued?			
d. Have you developed any new allergies?			
e. Have you used pesticides or other cholinesterase-inhibiting substances in a non-work setting?			
f. Have you used noise-producing items, such as firearms and machinery, without using hearing protective devices?			
g. Have you made any visits to health care providers that were not reported?			
h. Have you undergone hypnosis?			
i. Have you attempted suicide?			
j. Have you used illegal drugs or abused prescription drugs?			
k. Have you been involved in an alcohol-related incident, such as DWI or a bar fight?			
l. Have you been referred for or have you sought counseling for alcohol or drug use?			
m. Have you developed an illness you think is job-related and that you did not previously report?			
n. Have you changed jobs or work assignments due to illness?			
o. Have you changed job positions or have your duties changed?			
p. Have your work hazard exposures changed?			
q. Have you had difficulty wearing personal protective equipment required for your job?			
r. Have you had any trouble wearing your assigned respiratory protection equipment?			
s. Have you had any exposures that you did not report?			
t. Have you taken a second (part-time) job?			
u. Have you had work-related injuries that you did not report?			
v. Have you had work-related exposures to cholinesterase-inhibiting substances?			
w. Have you been told that you were exposed to substances associated with cardiovascular (heart) disease?			
x. Have you been told that you were exposed to substances associated with pulmonary (lung) disease?			
y. Have you been told that you were exposed to substances associated with neurological disease?			
z. Have you been told that you were exposed to substances associated with psychiatric disorders?			
aa. Have you had exposure to mustard or lewisite?			
bb. Have you had exposure to skin irritants or contact allergens?			
cc. Have you taken up any hobbies? (If so, please list them.)			
dd. Do you have a new or changed disability rating?			
ee. Are you or your spouse pregnant or planning pregnancy?			

(Continue on reverse)

PREPARED BY (Signature & Title)	DEPARTMENT/SERVICE/CLINIC	DATE (YYYYMMDD)
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PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)	<table style="width:100%;"> <tr> <td><input type="checkbox"/> HISTORY/PHYSICAL</td> <td><input type="checkbox"/> FLOW CHART</td> </tr> <tr> <td><input type="checkbox"/> OTHER EXAMINATION OR EVALUATION</td> <td><input type="checkbox"/> OTHER (Specify)</td> </tr> <tr> <td><input type="checkbox"/> DIAGNOSTIC STUDIES</td> <td></td> </tr> <tr> <td><input type="checkbox"/> TREATMENT</td> <td></td> </tr> </table>	<input type="checkbox"/> HISTORY/PHYSICAL	<input type="checkbox"/> FLOW CHART	<input type="checkbox"/> OTHER EXAMINATION OR EVALUATION	<input type="checkbox"/> OTHER (Specify)	<input type="checkbox"/> DIAGNOSTIC STUDIES		<input type="checkbox"/> TREATMENT	
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