NSN 7540-00-634-4176

600-108

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

TUBERCULOSIS SCREENING QUESTIONNAIRE

1) Has your child ever had contact with people who have confirmed or suspected contagious tuberculosis?

YES NO

2) Has your child immigrated from countries in Asia, the Middle East, Africa, or Latin America?

YES NO

3) Has your child traveled to countries in Asia, the Middle East, Africa, and/or Latin America or had significant contact with indigenous people from such countries?

YES NO

4) Does your child have ongoing exposure to any of the following people: HIV infected people, homeless people, residents of nursing homes, institutionalized adolescents or adults, illicit drug users, incarcerated adolescents or adults, or migrant farm workers?

YES NO

5) Does your child have any of the following illnesses? (please circle)
CANCER, AIDS/HIV, DIABETES, CHRONIC RENAL/KIDNEY FAILURE, IMMUNE DEFICIENCY

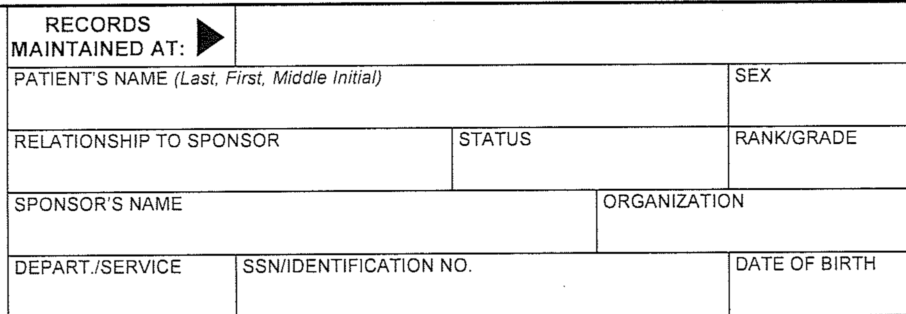
A/P:

Patient IS / IS NOT at risk

A TB skin test WILL / WILL NOT be ordered

Provider Signature/Stamp

PATIENT'S IDENTIFICATION *(Use this space for Mechanical Imprint)*



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

CHRONOLOGICAL RECORD OF MEDICAL CARE

STANDARD FORM 600 (REV. 5-84)
Prescribed by GSA and ICMR
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