

**CUI (When Filled Out)**

**MEDICAL RECORD**

**CHRONOLOGICAL RECORD OF MEDICAL CARE**

**PRIVACY ACT STATEMENT:** This information is subject to the Privacy Act of 1974 (5 U.S.C. Section 552a). This information may be provided to appropriate Government agencies when relevant to civil, criminal or regulatory investigations or prosecutions. The Social Security Number, authorized by Public Law 93-579 Section 7 (b) and Executive Order 9397, is used as a unique identifier to distinguish between employees with the same names and birth dates and to ensure that each individual's record in the system is complete and accurate and the information is properly attributed.

<b>S: Subjective</b>				
_____ year old ( ) male ( ) female reports for Martial Arts & Fitness Center of Excellence (MAFCE) screening which includes review/verification of risk factors and ensure readiness to the attached letter accompanying this document.				
Questions (to be filled out by <b>candidate</b> ):			Yes	No
Have you been on light duty or limited duty in the last 6 months? Explain: _____				
Chronic diseases or injuries that may affect my performance during maximal physical activity. Explain: _____				
Currently or have sought attention for physical therapy, occupational therapy, chiropractor, SMART clinic, or athletic training services in the last 3 months?				
Have you ever had any broken bones, stress fracture, or dislocated joints?				
Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?				
Do you CURRENTLY have a bone, muscle, or joint injury that bothers you?				
Do you CURRENTLY use a brace, foot orthotics, or other assistive device?				
Do you have any rashes, pressure sores, or other skin problems?				
Have you had a herpes or MRSA skin infection?				
Have you ever had an injury related to hot or cold weather?				
Do you or someone in your family have sickle-cell <b>trait</b> or <b>disease</b> ?				
Difficulty maintaining weight or body composition standards in the last 3 years?				
Are you fasting, restricting calories, or a certain food now or during the proposed class dates (include religious or performance)?				

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PATIENTS IDENTIFICATION: (For typed or written entries, give: Name – last, first, middle, ID NUMBER or Social Security Number, Gender, Date of Birth, Rank/Grade)		REGISTER NUMBER	WARD NUMBER

**CHRONOLOGICAL RECORD OF MEDICAL CARE**  
 Medical Record  
**STANDARD FORM 600 (rev. 9/2025)**  
 Prescribed by GSA/ICMR  
 FIRMR (41 CFR) 201-9.202-1

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	Do you have chronic injuries to Ear, Nose, or Throat? Example: swimmer's ear, infection, frequent nose bleeds?		
	Do you have any concerns that you would like to discuss with a primary care provider (PCM)?		
	Do you currently have an allergy and red dog tag?		
	List the supplements you are CURRENTLY taking (vitamins, protein, pre-workout, etc):		
	Further explanation on any questions:		
	<b>O: Objective (filled out by provider)</b>		
	I ( ) have ( ) have not reviewed the patient's self-report above		
	Periodic Health Assessment (PHA) is complete on _____ (Day Month Year)		
	Patient ( ) does ( ) does not have a plan associated with PHA to resolve items. Comments: _____		

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<b>MSK Systems Review</b>		YES	NO
Head, Neck	Is the patient currently experiencing pain or discomfort here <u>Side:</u> Left        Right        Both		
Head, C-spine Notes:			
Thoracic Spine	Is the patient currently experiencing pain or discomfort here <u>Side:</u> Left        Right        Both		
Thoracic Spine Notes:			
Lumbar Spine	Is the patient currently experiencing pain or discomfort here <u>Side:</u> Left        Right        Both		
Lumbar spine notes:			
Shoulder	Is the patient currently experiencing pain or discomfort here <u>Side:</u> Left        Right        Both		
Shoulder Notes:			
Elbow	Is the patient currently experiencing pain or discomfort here <u>Side:</u> Left        Right        Both		
Elbow Notes:			
Wrist	Is the patient currently experiencing pain or discomfort here <u>Side:</u> Left        Right        Both		
Wrist Notes:			
Hand, Fingers, Thumb	Is the patient currently experiencing pain or discomfort here <u>Side:</u> Left        Right        Both		
Hand, fingers, thumb notes:			
Hip	Is the patient currently experiencing pain or discomfort here <u>Side:</u> Left        Right        Both		
Hip Notes:			
Knee	Is the patient currently experiencing pain or discomfort here <u>Side:</u> Left        Right        Both		
Knee Notes:			

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	Lower leg	Is the patient currently experiencing pain or discomfort here <u>Side:</u> Left        Right        Both		
	Lower leg Notes:			
	Ankle	Is the patient currently experiencing pain or discomfort here <u>Side:</u> Left        Right        Both		
	Ankle Notes:			
	Foot, Arch, Toes	Is the patient currently experiencing pain or discomfort here <u>Side:</u> Left        Right        Both		
	Foot, Arch, Toes Notes:			
	<b>Concussion/ TBI</b>		YES	NO
	Has the patient performed a baseline or pre-screening electronic concussion test previously. If so, when was last test _____?			
	Has the patient ever had a head injury or concussion (TBI)? If so, approximately how many _____			
	Circle the symptoms the patient experienced: headache, dizziness, fogginess, confusion, nausea/vomiting, ringing in the ears (tinnitus), loss of consciousness, blurred/double vision, other: _____ About how many days until symptoms had resolved? _____ Did this injury ever require hospitalization? _____ Did the patient complete a structured return-to-train protocol? _____			
	Does the patient have a history of seizure disorder?			
	Does the patient have headaches with exercise?			
	Does the patient currently have any numbness, tingling, or weakness in your arms and legs? If so, was this as a result of a blow to the head? _____			
	Does you have any concerns in regards to cognitive abilities, balance, vision, reaction time, or otherwise related to head injury prior to this course?			
	<b>Mental Health</b>		YES	NO
	Are currently using mental health services or counseling services?			
	Do you require continuation of services during the course?			
	Do you have a plan for managing symptoms/stress during the course?			

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	<b>Cardiovascular</b>	YES	NO
	Do you currently have any symptoms including chest pain, palpitations, heart racing, dizziness or sensation of passing out with high exertion?		
	Have you ever been diagnosed with any heart condition (irregular heartbeats, murmurs, abnormal ECG)?		
	If so, list all known studies that were completed: Did this require hospitalization (y/n)? Are you currently or have you been on medications related to this (y/n)?		
	<b>Summary and disposition</b>		
	Additional Notes:		
	Circle one:		
	Cleared with full participation/Cleared with recommendations/ <b>Not</b> cleared for participation		
	I have examined the patient named above and completed the pre-participation physical evaluation. A copy of this physical exam is on record according to local MTF requirements. If conditions arise after the patient has been cleared for participation, the provider may rescind the recommendation until the problem is resolved or evaluated.		
	Signature or Stamp:		
	Date:		

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