I. AUTHORITY: TCA 4-3-603, TCA 4-3-606, TCA 68-11-301, TCA 68-11-303, TCA 68-11-311, TCA 24-7-110, TCA 68-11-209, TCA 32-11-102, and TCA 32-11-105.

II. PURPOSE: To prescribe contents and handling procedures for inmate health records.

III. APPLICATION: Wardens/Superintendents, Health Administrators, health care and archives staff, and privately managed institutions.

IV. DEFINITIONS:

A. Advanced Directive: An individual instruction or written statement relating to the subsequent provision of health care for the individual in which the inmate or his/her healthcare agent expresses his/her choice(s) regarding healthcare services to apply in the event he/she is no longer capable of expressing a choice. Advance directives may include by not be limited to, a living will, an advance care plan, or durable power of attorney for health care.

B. Authorized Provider: A physician, dentist, Advanced Practice Nurse (APN), or Physician's Assistant (PA).

C. Central Office Warehouse (COW): The Tennessee Department of Correction (TDOC) central storage location for inactive records.

D. DeBerry Special Needs Facility (DSNF) Health Record: A health record maintained by the DSNF facility for sub-acute or extended care inmates being treated in a medical or mental health temporary or permanent status.

E. Healthcare Agent: A fiduciary or legal surrogate. A fiduciary is a legal guardian or conservator, or an attorney-in-fact who has been granted a valid power of attorney for health care decisions pursuant to applicable law.

F. Health Record: A chronological documentation of an inmate's medical history and treatment. The record includes documentation of intake health screenings, progress notes, x-ray and laboratory reports, physicians' orders, clinic and infirmary records, medication administration records, treatment plans, immunization records, dental records, hospital and emergency room reports, specialty consultation reports, mental health records, etc.

G. Now/Stat Order: An order or procedure to be initiated and completed without delay.

H. Order: Instructions from an authorized provider.

I. Protocol order: Orders initiated by TDOC Nursing Protocols

J. Routine Order: An order to be initiated and completed within twenty-four hours

K. S.O.A.P. Notes: A particular format of recording clinical documentation regarding treatment procedures. The four components of S.O.A.P. notes are:

S = Subjective-describes the patient's current condition in narrative form, including the patient's reported complaint(s), history, symptoms, onset, and previous remedies.

O = Objective-findings from physical examinations, diagnostic tests, vital signs, age, weight, height, etc.

A = Assessment-summary of the clinician's diagnostic impression and rule-outs.

P = Plan-specifies the treatment plan for the inmate's condition, intervention, medication, required follow-up, etc.

L. Telephone Order: Order initiated by telephone.

M. Urgent Order: Orders which should be completed within one hour.

N. Verbal Orders: Orders given verbally by a licensed provider to a licensed nurse, or pharmacist.

V. POLICY: A health record shall be maintained for each inmate. The health record shall contain a chronological documentation of the inmate's health status and treatment throughout the duration of his or her incarceration. The health record shall be maintained separately from the inmate's institutional record.

VI. PROCEDURES:

A. GENERAL:

1. The health record shall be initially created at diagnostic centers as part of the diagnostic process, per Policy #401.04. In the event that an inmate returns to TDOC custody, his/her original health records shall be requested from TDOC health record archives. Diagnostic centers shall procure and utilize a ten compartment brown letter size folder for the health record as specified in Policy #512.01. These folders shall also be available to other institutions for replacement or creation of additional volumes of a health record. The Chief Medical Officer shall approve the method of recording entries in the records, the form and format of the records, and the procedures for their maintenance and safekeeping.

2. The original health record shall accompany the inmate whenever he/she is transferred to another TDOC facility either permanently or temporarily (e.g., court, hospital, etc.). Mental health programmatic records shall also be forwarded. (See Policies #113.04 and #113.81)

3. The health record shall be organized in a problem-oriented format and contain documentation of all occasions of medical service provided to inmates both onsite and off site for either inpatient or ambulatory care.

4. Prior to filing the health record, all documents are to be reviewed to ensure that they are filed in the correct section of the health record.

B. Confidentiality/Release of Health Records: All health records shall be considered confidential and are to be handled in accordance with Policy #113.52.

C. Maintenance of Health Records:

1. All active health records shall be stored in a secure area and separately maintained from the institutional record. Only authorized personnel shall have access to these records. Each facility shall maintain a list of personnel, by position or function, authorized to have access to the health record, and only those authorized individuals shall have access to the DSRS database as well as the original health record.

2. Records In/Records Out, CR-1006, shall be used anytime an inmate health record is removed from the health records area.

3. All institutions shall utilize the color-coded terminal digit system for storage and retrieval.

D. Health Services Forms:

1. All institutions shall use the TDOC approved CR forms in the health record. Exceptions can be made only as described in Policy #101.06. All CR forms shall be completed in their entirety.

2. The Chief Medical Officer (CMO) or designee shall periodically, or as needed, review health services forms for content and appropriateness to correspond with TDOC policy, ACA standards, and current health service standards.

3. S.O.A.P. note~~s~~ format shall be used for documenting clinical assessments in the health record; all other notes may be narrative.

4. Prescriber Orders: All orders for treatment shall be written on the Physician's Orders, CR-1892, by an authorized provider with the exception of situations that may require the provider to issue an order verbally or by telephone so that treatment can begin immediately.

a. Now/Stat Order: This request applies to an emergent situation. The process of obtaining the requested order or procedure shall be initiated without delay. These requests may be written or verbal orders. The order must contain now/stat as part of the order and shall be handed directly to licensed personnel with notification of the stat order.

b. Protocol Orders: May be used in situations outlined in Policy #113.11. In order for protocol orders to be carried out the orders should be written congruent with the requirements specified by the TDOC Nursing Protocols.

c. Routine Order: The process of obtaining the requested order and shall be completed/processed within twenty-four hours. The process is initiated by the ordering provider flagging the chart by folding the order over itself to the right and placing it in the designated area at each facility.

d. Telephone Orders: Only licensed personnel can receive and document telephone orders in the medical record. All telephone orders shall be documented, and verified by reading the order back to the authorized provider. The provider then becomes responsible for the order that is to be treated as all other physician orders. The licensed personnel shall document the date and time of the order, their name and title, as well as, that of the licensed provider giving the order.

e. Urgent Order: The process of obtaining the requested order or procedure and shall be completed within one hour of the request. The order must contain "urgent" as part of the order with notification of an urgent order. The process is initiated by the provider handing the written orders to licensed personnel.

f. Verbal Order: An order that is initiated orally by licensed personnel without the aid of a telephone. Verbal orders are not permitted except in cases of emergent situations when the provider is physically unable to interrupt his/her activity to write the order.

g. Transcription/Notation of Provider Orders: Licensed nursing staff will transcribe/notate physician orders for treatment onto the appropriate CR form(s) as applicable. Once completed the licensed nurse will date, time, and sign under the order indicating treatment orders were initiated.

h. 24 Hour Order Verification: The health administrator at each facility will have a procedure to verify orders written by providers in the last 24 hours were transcribed and notated correctly.

E. Organization of the Health Record: All documents placed in an inmate's health record shall be legible and attached face up, in chronological order, with the most recent information on top. A health record consists of ten sections. See Section VI.(F)(3)(a) of this policy for Section I organization. Items are placed in the most appropriate general category as follows:

1. Section 1- Assessment Data, Treatment Plan(s), Advance Directives conservatorships

2. Section 2 - Diagnostic Reports

3. Section 3 - Provider Orders/Medication Administration Records

4. Section 4 - Progress Notes

5. Section 5 - Consultations

6. Section 6 - Dental

7. Section 7 - Infirmary

8. Section 8 - Discharge Summaries

9. Section 9 - Miscellaneous

10. Section 10- Mental Health

F. Contents of Health Record Volumes:

1. Additional health record volumes should be made when documents do not fit on fasteners/prongs in sections.

2. All volumes must have typed name labels and color-coded tabs with complete inmate/patient name and TDOC number visible. Volumes shall be continued in sequence, e.g., I of II or II of II.

3. The current forms shall be transferred from the previous volume to the new volume and placed in the appropriate category grouped together, in chronological order as follows:

a. Section I – Assessment Data

(1) Advance Directives

(2) Conservatorship (if applicable)

(3) Major Problem List, CR-1894

(4) Chronic Disease Clinic Treatment Plan, CR-3624

(5) Teaching/Counseling Plan, CR-2742

(6) Immunization/TB Control Record, CR-2217

(7) Inmate/Employee Tuberculosis Screening Tool CR-3628

(8) Health Classification Summary, CR-1886

(9) Report of Physical Examination, CR-3885

(10) Health History, CR-2007

b. Section II –Diagnostic Reports

(1) All initial and current laboratory reports (past 12 months)

(2) All diagnostic reports (past 12 months)

c. Section III – Provider Orders/Medication Administration Records: Initial and at least most recent six months

d. Section IV – Progress Notes: Initial clinical assessment note and at least six months of Problem Oriented Progress Record, CR-1884 (in chronological order)

e. Section V – Consultations- All specialty consultation requests and reports (past 12 months)

f. Section VI – Dental- transfer all forms and pan-oral x-ray

g. Section VII – Infirmary- All in house infirmary progress notes

h. Section VIII – Discharge Summaries- All hospital discharge summaries, as well as the DeBerry Special Needs Facility health record

i. Section IX- Miscellaneous - Miscellaneous initial or most current Health Questionnaire, CR-2178

j. Section X- Mental Health

(1) Initial Psychological Evaluation

(2) Consent for Treatment, CR-1897

(3) Initial and current Mental Health Treatment Plan(s), CR-3326

(4) Mental Health Treatment Review Committee form, CR-3329

(5) Initial and 12 months – Progress Notes, CR-1884

(6) Any other mental health related forms

G. Documentation of the DSNF Health Record:

1. The DSNF health record shall be standardized and uniform in format for medical and mental health services, and approved annually in writing by the TDOC Chief Medical Officer.

2. When an inmate is discharged from DSNF, a copy of the discharge summary and any pertinent consultations or diagnostic examinations shall be copied from the DSNF health record and placed in the inmate's original health record. The DSNF health record shall be retained by the DSNF medical records department.

3. DSNF shall develop its own individual chart arrangement according to its unique treatment modalities. At the time of discharge, the DSNF health record shall be reviewed to ensure completeness, proper form arrangement, and that a discharge summary is present.

H. Documentation of Infirmary Services: All entries concerning care while the inmate is admitted to the infirmary will be maintained in Section VII.

I. Psychiatric/Psychological Treatment Records: Psychiatric/psychological summaries, reports, evaluations, and progress notes shall be included in the inmate health record in order to facilitate follow-up, promote continuity of care, and to document ongoing treatment.

J. Record Review: Prior to transfer from any institution, the health record shall be reviewed by the Health Administrator or designee. The reviewer shall verify that the health record is complete and organized in accordance with Section VI.(E) of this policy.

K. Health Record Retention and Disposition:

1. After the release, parole, or discharge of an inmate, the health record shall be retained for a period of seven years. Following the death of an inmate the record shall be retained for a period of 15 years. Prenatal records shall be retained for a period of 19 years.

2. Following any inmate's escape for longer than 30 days, his/her release or death, the health record shall be forwarded to the COW, utilizing the Health Records Movement Document, CR-2176. Such records shall be made available thereafter as needed, or upon the inmate's return to TDOC custody. Requests for such records shall be forwarded to the TDOC health record Archives Center.

3. A copy of health records shall be released to the Office of Investigations and Compliance (OIC) when requested. (See Policy #113.05) The Health Administrator shall retain the original health record.

L. Coding and Indexing:

1. If coding is done for medical diagnosis, the most current edition of *The International Classification of Diseases, Clinical Modification*, shall be used.

2. If coding is done for psychiatric diagnoses, the most current edition of the *Diagnostic and Statistical Manual of Disorders* (DSM), by the American Psychiatric Association, shall be used.

M. Advance Directives and Health Care Agent Documentation: In accordance with Policy #113.51, inmates may make advance directives to express their choices regarding their healthcare services; to apply in the event that they are no longer capable of expressing a choice. Such advance directives may include a "Living Will", or an "Advance Care Plan."

As also described in Policy #113.51, a "healthcare agent" may in some cases be appointed to make healthcare decisions for an inmate in circumstances where the inmate is not able to do so for him/herself Such appointments include an "Appointment of Healthcare Agent," Durable Power of Attorney for Healthcare," or an "Appointment of a Conservator".

1. Advance directives and Healthcare Agent documents shall be entered into the health record and shall be filed in Section 1 of the health record.

2. Health records containing advance directives and/or documentation of a healthcare agent appointment shall be prominently marked on the outside front of the health record file "Contains Advance Directives," and/or "Contains documentation of Healthcare Agent appointment." Marking shall be by a paste-on label or bold print in red. The label or printing shall be in the upper right hand corner of the jacket.

3. Health Services staff shall ensure that the inmate's treatment plan includes a reference to advance directives and is approved by signature of the inmate's healthcare agent, where required.

4. When an inmate is transferred to a community hospital, a copy of the advance directive and/or healthcare agent appointment shall be forwarded to that hospital. A responsible individual at the community hospital shall sign for the receipt of the advance directive and/or documentation of health care agent appointment. This receipt shall be filed in Section 1 of the health record.

5. If necessary, facilities shall develop additional processes outlining how inmates with conservators or other healthcare agents will be readily identified. If a healthcare agent has been terminated, the documentation thereof shall be transferred to Section IX, together with documentation that the agent has been terminated.

VII. ACA STANDARDS: 4-4352, 4-4413, 4-4414, and 4-4415.

VIII. EXPIRATION DATE: March 1, 2023.

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH TREATMENT REVIEW COMMITTEE
DEBERRY SPECIAL NEEDS FACILITY

INMATE NAME: _____ NUMBER: _____ DATE OF BIRTH: _____ SEX: _____

I. REPORT OF INITIAL PSYCHIATRIST'S MEETING WITH INMATE'S:

Initial Psychiatrist's Recommendation(s):

_____ _____
Inmate's Signature Date

_____ _____
Psychiatrist Signature Date

II. REPORT OF SECOND PSYCHIATRIST'S MEETING WITH INMATE:

Second Psychiatrist's Recommendation(s):

_____ _____
Inmate's Signature Date

_____ _____
Psychiatrist Signature Date

III. REPORT OF TREATMENT TEAM MEETING:

Treatment Team Recommendations(s):

Signature(s) of Treatment Team Member(s):	Date	Comments:
_____ Title		
_____ Title		
_____ Title		
_____ Title		

MENTAL HEALTH TREATMENT REVIEW COMMITTEE
DEBERRY SPECIAL NEEDS FACILITY

IV. REPORT OF TREATMENT REVIEW COMMITTEE:

Signature of Treatment Review Committee:	Date	Comments:
_____ Title	_____	_____
_____ Title	_____	_____
_____ Title	_____	_____

INMATE RIGHTS ADVOCATE COMMENT(S):

_____ Inmate Rights Advocate Signature

_____ Date

TENNESSEE DEPARTMENT OF CORRECTION

INMATE/EMPLOYEE TUBERCULOSIS SCREENING TOOL

INSTITUTION

☐ Employee ☐ Inmate

Inmate Name (Printed) | Inmate Number

Employee Name (Printed) | Last four (4) digits of Employee SS#

Tennessee Department of Correction (TDOC) Policy requires annual screening for tuberculosis. This tool is to be used annually and whenever tuberculosis is suspected.

Have you experienced any of the following symptoms within the last year?

		YES	NO
1.	Prolonged cough (*lasting 3 weeks or longer*)	☐	☐
2.	Productive cough (*if yes, state color*)	☐	☐
3.	Coughing up blood	☐	☐
4.	Chest pain	☐	☐
5.	Get tired easily	☐	☐
6.	Weight loss (*if yes, how many lbs._____, time period _____*)	☐	☐
7.	Loss of appetite	☐	☐
8.	Night sweats	☐	☐
9.	Fever or chills	☐	☐

Are you immunocompromised? (Diabetes, End stage renal disease, cancer, HIV, prolonged corticosteroid therapy, gastric bypass or immunosuppressive arthritic therapy)	☐	☐
Were you given BCG at any time?	☐	☐
Have you traveled to Asia, the Caribbean, South America, or Africa within the last year? (***employee only***)	☐	☐
Have you ever had a positive TB skin test or positive TB blood test?	☐	☐
Have you ever been told that you had tuberculosis?	☐	☐
Do you Volunteer to a homeless shelter on a regular basis? (***employee only***)	☐	☐
Have you ever taken medication for TB?	☐	☐

List medications: _____ Treatment date(s): _____

Most recent TST/IGRA Date: _____ Result: _____ mm: _____

Most recent Chest-X-ray Date: _____ Result: _____

Current Test PPD (Brand): _____ Lot#: _____ Exp Date: _____

Date placed: _____ Site: _____ Nurse: _____

Date read: _____ Result: _____ mm Nurse: _____

Date of IGRA _____ Result: _____ Nurse: _____

Exposure Control Methods Implemented

☐ No action required	☐ Physician/Mid-Level Referral;
☐ Segregated from population	☐ Immediate physician referral
☐ Surgical mask on patient	☐ Prepare for transfer to All facility
☐ Placed in All	☐ Recommend Quanti-FERON Blood Test

Physician review required for all positive findings:

Employee/Inmate Signature | Date

Reviewing Physician/Mid-Level Referral Signature | Date

Health Care Provider Signature | Date

PHYSICIAN'S ORDERS

NAME

TDOC ID

ROOM No.

PHYSICIAN

Drug Allergies

Date & Time		DO NOT USE THIS SHEET UNLESS A RED NUMBER SHOWS → 1	Nurse's Initials

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES

MAJOR PROBLEM LIST

_____
INSTITUTION

Name: _____ TDOC ID: _____
Last First Middle

Date of Birth: _____ Gender: ☐ M ☐ F Race: _____

Allergies: _____

PROBLEM NUMBER*	DATE IDENTIFIED/ RECORDED	MAJOR CLINICAL CONDITIONS/PROBLEMS	RESOLVED *(Please check "√" if resolved)*	RESOLVE DATE

Conservator Name: _____

Primary Phone: _____ Secondary Phone: _____

* Major medical problems considered medical or surgical in nature are identified by Roman numerals, i.e., **I** – Diabetes, **II** – Laminectomy.
* Psychiatric, or serious psychological problems, are identified by capital letters, i.e., **A** – Schizophrenia, **B** – Self-Mutilative Behavior.

TENNESSEE DEPARTMENT OF CORRECTION

CHRONIC DISEASE CLINIC
TREATMENT PLAN

Inmate Name _____

TDOC ID _____ Institution _____

LIST CHRONIC DISEASES

1) _____ 3) _____ 5) _____
2) _____ 4) _____ 6) _____

Either list or refer to pharmacy profile for current medications:

_____

***SUBJECTIVE*:**

Asthma: # attacks in last month? _____
short acting beta agonist canisters in last month? _____
times awakening with asthma symptoms per week? _____
CV/hypertension (Y/N): Chest pain? _____ SOB? _____ Palpitations? _____ Ankle edema? _____
HIV/HCV (Y/N): Nausea/vomiting? _____ Abdominal pain/swelling? _____ Diarrhea? _____ Rashes/lesions? _____

Seizure disorder: # seizures since last visit? _____
Diabetes mellitus: # hypoglycemic reactions since last visit? _____
Weight loss/gain ↑ ↓ _____ lbs.

For all diseases, since last visit, describe new symptoms:

_____

***OBJECTIVE*:**

Patient adherence (Y/N): with medications? _____ with diet? _____ with exercise? _____
Vital signs: Temp _____ BP _____ Pulse _____ Resp _____ Wt _____ PEFR _____ INR _____
Labs: Hgb A1C _____ HIV VL _____ CD4 _____ Total Chol _____ LDL _____ HDL _____ Trig _____
Range of fingerstick glucose/BP monitoring: _____

Physical Evaluation (PE): _____

HEENT/neck:	Extremities:
Heart:	Neurological:
Lungs:	GU/rectal:
Abdomen:	Other:

Additional Comments: _____

ASSESSMENT:	**Degree of Control***				**Clinical Status***			
	G	**F**	**P**	**NA**	**I**	**S**	**W**	**NA**
1 _____	☐	☐	☐	☐	☐	☐	☐	☐
2 _____	☐	☐	☐	☐	☐	☐	☐	☐
3 _____	☐	☐	☐	☐	☐	☐	☐	☐
4 _____	☐	☐	☐	☐	☐	☐	☐	☐

***Degree of Control**: *G-Good F-Fair P-Poor NA-Not Applicable*
***Clinical Status**: *I-Improved S-Same W-Worse NA-Not Applicable*

PLAN:

Medication changes:
Diagnostics: _____
Labs: _____
Monitoring: BP _____ x day/week/month Glucose _____ x day/week/month Peak flow _____ Other: _____
Education provided: ☐ Nutrition ☐ Exercise ☐ Smoking ☐ Test results ☐ Medication management ☐ Other: _____
Referral (list type): _____ Specialist: _____
days to next visit? ☐ 90 ☐ 60 ☐ 30 ☐ Other: _____ Discharged from Chronic Clinic (specify clinic): _____
Additional Comments: _____

_____ _____
Mid-Level / Physician Signature Date

TENNESSEE DEPARTMENT OF CORRECTION

TEACHING/COUNSELING PLAN

Patient's Name/TDOC ID _____ Subject _____

ELEMENT	DATES TAUGHT
Element: _____ _____ Provider Signature: _____ Patient Signature: _____	
Element: _____ _____ Provider Signature: _____ Patient Signature: _____	
Element: _____ _____ Provider Signature: _____ Patient Signature: _____	
Element: _____ _____ Provider Signature: _____ Patient Signature: _____	
Element: _____ _____ Provider Signature: _____ Patient Signature: _____	
Element: _____ _____ Provider Signature: _____ Patient Signature: _____	

Note: Each entry must be signed.

TENNESSEE DEPARTMENT OF CORRECTION

IMMUNIZATION / TB CONTROL RECORD - INMATE

Enter Institution.
INSTITUTION

NAME Enter Name. TDOC ID: Enter TDOC ID.

IMMUNIZATIONS

DATE	VACCINE	DOSE	SIGNATURE
Enter Date.	Enter Vaccine.	Dose.	
Enter Date.	Enter Vaccine.	Dose.	
Enter Date.	Enter Vaccine.	Dose.	
Enter Date.	Enter Vaccine.	Dose.	
Enter Date.	Enter Vaccine.	Dose.	

TUBERCULOSIS SCREENING AND SURVEILLANCE

INITIAL SCREENING:

Date IGRA Drawn	Date of Results	Reaction (Neg/Pos)	Chest X-Ray Date / Results		Preventive Treatment Started / Completed	
Enter IGRA Drawn Date.	Enter IGRA Drawn Date.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.

PERIODIC SCREENING: READ AFTER 48 – 72 HOURS IN MM

Tuberculin Test Date Antigen/Method/Initials		Date Read / Initials		Reaction in MM	Chest X-Ray Date / Results		Preventive Treatment Started / Completed	
Enter Test Date.	Enter Antigen/Method/Initials.	Enter Read Date.	Enter Initials.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.
Enter Test Date.	Enter Antigen/Method/Initials.	Enter Read Date.	Enter Initials.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.
Enter Test Date.	Enter Antigen/Method/Initials.	Enter Read Date.	Enter Initials.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.
Enter Test Date.	Enter Antigen/Method/Initials.	Enter Read Date.	Enter Initials.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.
Enter Test Date.	Enter Antigen/Method/Initials.	Enter Read Date.	Enter Initials.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.
Enter Test Date.	Enter Antigen/Method/Initials.	Enter Read Date.	Enter Initials.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.
Enter Test Date.	Enter Antigen/Method/Initials.	Enter Read Date.	Enter Initials.	Enter Reaction.	Enter X-Ray Date.	Enter Results.	Enter Started Date.	Enter Completed Date.

TUBERCULOSIS SURVEILLANCE: FILL IN IF POSITIVE PPD OR IF DISEASE OCCURS

Bacteriologic Examination Date / Results		Diagnosis Date / Diagnosis		Treatment Started / Completed	
Enter Date.	Enter Results.	Enter Date.	Enter Diagnosis.	Enter Started Date.	Enter Completed Date.
Enter Date.	Enter Results.	Enter Date.	Enter Results.	Enter Started Date.	Enter Completed Date.
Enter Date.	Enter Results.	Enter Date.	Enter Diagnosis.	Enter Started Date.	Enter Completed Date.
Enter Date.	Enter Results.	Enter Date.	Enter Diagnosis.	Enter Started Date.	Enter Completed Date.

☐ Report Complete

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH CLASSIFICATION SUMMARY

Name: _____ TDOC ID#: _____ Date of Birth: _____

Physical Exam Date: _____ Dental Exam Date: _____

Allergies: _____

Health Classification (Code):	Code	Description
	A	Class A – No Restrictions
	B	Class B – Moderate Restrictions
	C	Class C – Severe Restrictions

Level of Care (LOC): _____ *Based on health record information provided by Mental Health Treatment Team*		
	LOC 1	No Mental Health Services
	LOC 2	Outpatient
	LOC 3	Supportive Living Services (SLU) Moderate Impairment
	LOC 4	Supportive Living Services (SLU) Severe Impairment
	LOC 5	None

Clinical Alert: _____ Date: _____ Note: _____

Health Related Conditions (Codes): _____
(Circle all applicable codes)

Code	Health Conditions	Code	Health Conditions
A	Visual Impairment	P	Neurological Disease/Disorder ☐ Dementia
B	Hearing Impairment	Q	Arthritis
C	Speech Impairment	R	Obesity (BMI >40)
D	Orthopedic Disease/Disorder ☐ Documented Hx of Back Problems	S	Aging (>60)
		T	Dermatological Disease/Disorder
E	Amputation/Missing Extremity	U	Prosthetic Device Associated with Disability
F	Pregnancy ☐ 1st ☐ 2nd ☐ 3rd (Trimester)	V	(Specify)_____
G	Cancer		
H	Asthma/Hay Fever	W	Permanently confined to a Wheelchair/Mobility
I	Allergies a)Drug: _____ b)Other: _____	X	Sleep Apnea
		Y	G. U. Disease
J	Diabetes ☐ BS >300	Z	Surgery within last 6 months (abdominal, chest, back, or upper extremity)
K	Seizure Disorder		
L	Cardiovascular Disease/Disorder	AA	Other: _____
M	Hypertension		
N	Pulmonary Disease/Disorder	BB	Acute Injury/Serious Medical Condition: Specify _____

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH CLASSIFICATION SUMMARY

Name: _____ TDOC ID#: _____ Date of Birth: _____

Specific Restrictions (Codes): _____
(Circle all applicable codes)

Specific Accommodations (Codes): _____
(Circle all applicable codes)

Code	Restrictions
A	Complete bed rest or limited activity(C)
B	Sedentary work only-lifting 10 lbs. maximum, occasional walking or standing (C)
C	No heavy lifting-20lbs. maximum, able to frequently lift or carry objects up to 10 lbs. (B)
D	Light work only-lifting 50 lbs. maximum, able to frequently lift or carry objects weighing up to 20 lbs.(B)
E	Medium work only-lifting 100 lbs. maximum, able to frequently lift or carry objects weighing up to 50 lbs.(B)
F	Limited strenuous activity for extended periods of time:>1hr (B); 1hr (C); <1hr (C) Note:
G	Continuous standing or walking for extended periods of time:>1hr (B); 1hr (C); <1hr (C) Note:
H	Repetitive stooping or bending (B)
I	Acute need to be housed on first floor/bottom bunk(B)
J	Climbing and balancing (uneven ground) (B)
K	Exposure to loud noises or work detail with prolonged exposure (B)
L	Avoid areas or work details with exposure to skin irritants (B)
M	Participation in weight lifting or strenuous athletics(B)
N	Activity involving potentially dangerous machinery or equipment
O	Operation of motor vehicles (B)
P	Activity involving food preparation/handling (B)
Q	Prolonged exposure to sun or high temperatures (B)
R	Outside work detail during Spring or Summer (B)
S	Exposure to chemicals producing fumes or equipment producing dust (B)

Code	Accommodations
A	Prosthetic Limbs
B	Altered Accommodation (furniture, cell, etc.)
C	Air way assists (Oxygen, CPAP, BiPAP, etc.)
D	Sleeping Accommodation (pillow, blanket, mattress, etc.)
E	Ostomy Supplies
F	Catheter Supplies
G	Assist Devices (cane, crutches, walker, braces, wheel chair)
H	Inmate helper
I	Minimal Assistance for transporting in a van or bus
J	Wheel chair, bus or van required for transport
K	Non-emergency ambulance required for transport
L	Housed on first floor
M	Bottom bunk in housing assignment
N	Special footwear required

Notes:

_____

_____

_____

_____

_____ _____
Medical Practitioner Signature Date

REVIEWED

_____ _____
Medical Practitioner Signature Date

TENNESSEE DEPARTMENT OF CORRECTION

REPORT OF PHYSICAL EXAMINATION

INSTITUTION: _____

NAME _____ **TDOC ID#:** _____ **DATE OF EXAM** _____

Blood Pressure (sitting): _____ Height: _____ Weight: _____ Temp: _____ Pulse: _____ Resp: _____

CLINICAL EVALUATION			
NORMAL	(Check each item in appropriate column; enter ***"NE"*** if not evaluated.)	**ABNORMAL**	**NOTES**: Describe every abnormality in detail. Enter pertinent item number before each comment. Use progress notes for additional information.
	1. GENERAL: Appearance, Nails, Skin, and Identifying Marks, Tattoos, etc.		
	2. EYES: General, Ophthalmoscopic; Pupils, and Ocular Motility		
	3. HEAD AND NECK		
	4. EARS: External and Otoscopic		
	5. MOUTH AND THROAT		
	6. NOSE AND SINUSES		
	7. LUNG AND CHEST		
	8. CARDIOVASCULAR: Heart and Vascular System		
	9. ABDOMEN: Inspection, Auscultation and Palpation		
	10. RECTUM AND ANUS: Hemorrhoids, Fistulae and Prostate, if indicated.		
	11. G.U. SYSTEM a. Genitalia b. Hernia		
	12. PELVIC		
	13. ENDOCRINE		
	14. MUSCULOSKELETAL SYSTEM: Spine, Upper Extremities and Lower Extremities		
	15. NEUROLOGICAL: Cranial Nerves, Motor Functions, Cerebella and DTR's		
	16. PSYCHIATRIC		

Summary of Defects/Conditions and Diagnosis continued on back. ☐

Advanced Directives

Inmate has been counseled and informed regarding Advance Directives ☐ (PH-4194 completed and placed in inmate health record)

An existing PH-4194, Advanced Care Plan, is on file and has been reviewed for updates ☐

HEALTH CLASSIFICATION BASED ON PHYSICAL EXAMINATION: _____

_____ _____

PRINTED NAME OF MEDICAL PROVIDER SIGNATURE OF MEDICAL PROVIDER

Duplicate as Needed

TENNESSEE DEPARTMENT OF CORRECTION

REPORT OF PHYSICAL EXAMINATION

Summary of Defects/Conditions and Diagnosis

Duplicate as Needed

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH QUESTIONNAIRE

INMATE NAME: _____ TDOC ID _____ DOB _____

RECEIVING INSTITUTION: _____ DATE: ___/___/_____ TIME: _____ a.m./p.m.

INITIAL INTAKE: _____ TEMPORARY TRANSFER: _____ PERMANENT TRANSFER: _____

INQUIRE:

1. Do you have any barriers to learning? ☐ Vision ☐ Hearing ☐ Reading ☐ Writing ☐ None
2. Do you speak/read English? Speak: ☐ Yes ☐ No Read: ☐ Yes ☐ No
3.. Have you ever had a positive TB test? ☐ Yes ☐ No If **yes**, describe _____
4. Are you being treated for any illness or health problem (*including dental, venereal disease, or other infectious diseases*)?
   ☐ Yes ☐ No If **yes**, describe: _____
5. Do you have any physical, mental or dental complaints at this time? ☐ Yes ☐ No
   If **yes**, describe: _____
6. Are you currently taking any medication(s)? ☐ Yes ☐ No
   If **yes**, was the medication transferred with the inmate? ☐ Yes ☐ No
   If **yes**, describe (what used, how much, how often, date of last use, and any problems)
7. Have you recently or in the past, abused alcohol or other drugs, including prescription drugs? ☐ Yes ☐ No
   If yes, What? _____ How much? _____
8. Have you ever been hospitalized for using alcohol or other drugs, including prescription drugs? ☐ Yes ☐ No
   If **yes**, when? _____
9. Do you have any allergies? ☐ Yes ☐ No If **yes**, describe: _____

(For women)

10. a) LMP _____ b) Are you pregnant? ☐ Yes ☐ No Number of months _____
    c) Have you recently delivered? ☐ Yes ☐ No Date: _____
    d) Are you on birth control pills? ☐ Yes ☐ No
    e) Any gynecological problems? ☐ Yes ☐ No
11. Screening for MRSA Infections:
    a) Do you have any lesions, sores or insect bites? ☐ Yes ☐ No
    If **so**, do you have any open/draining lesions, sores, or insect bites? ☐ Yes ☐ No
    If **yes**, where are these lesions? _____

OBSERVE:

1. Behavior (including state of awareness, mental status, appearance, conduct, tremor and sweating):
   ☐ Normal ☐ Abnormal If **abnormal**, describe: _____
2. Skin Assessment (*including needle marks, trauma markings, bruises, lesions, jaundice, rashes, tattoos, and infestation(s)*
   ☐Yes ☐ No
   If **yes**, describe: _____
3. Is there evidence of Abuse or Trauma? ☐ Yes ☐ No If yes, describe: _____

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH QUESTIONNAIRE

MENTAL HEALTH:

1. Is the inmate presenting behavior(s) that are considered: ☐ Anxious ☐ Antagonistic/Hostile ☐ Hallucinations ☐ Withdrawn/Avoidant ☐ Depressed/Hopeless ☐ No
2. Is the inmate presenting disorganized thought? (*Unable to track questions and/or present responses in logical or connected manner*) ☐ Yes ☐ No
3. Have you ever been in a mental hospital? ☐ Yes ☐ No
   If **yes**, when? _____ How often? _____
4. Have you ever been treated for mental health? ☐ Yes ☐ No
   Have you ever been treated for substance use? ☐ Yes ☐ No
5. Have you ever attempted to kill yourself? ☐ Yes ☐ No If **yes**, when? _____
   How? _____ How many times? _____
6. Are you thinking about suicide now? ☐ Yes ☐ No
   If yes, do you have a plan? ☐ Yes ☐ No
7. Has a parent, other family member, or close friend committed suicide? ☐ Yes ☐ No If **yes**, who? _____
8.. Do you have a history of past or current head trauma? ☐ Yes ☐ No If **yes**, explain type of injury: _____
   _____
9.. As an adult or child, have you personally experienced being: ☐ Sexually abused ☐ Physically abused ☐ Emotionally abused
   ☐Yes ☐ No ☐Yes ☐ No ☐Yes ☐ No
   When? (year) and by whom? _____

DISPOSITION:

_____ Intake housing _____ Intake housing with prompt referral appointment *(health, mental health, substance use treatment)*

_____ General housing _____ General housing with prompt/referral appointment

Referred to appropriate health, mental health or substance use provider ☐ Yes ☐ No

Contacted appropriate health, mental health, or substance use provider due to emergency ☐ Yes ☐ No

Additional comments on Progress Notes (CR-1884): ☐ Yes ☐ No

I have received information regarding the procedure for obtaining routine and emergency health care (*medical, dental, substance use, and/or mental health, and co-pay requirements*). These have been explained to me and I understand how to access healthcare services in the form of:

☐ **Orientation Handbook (i.e. Inmate Handbook)**
☐ **Transient inmate information-describing how to access healthcare**

_____
Inmate Signature

_____
Employee Name Printed

_____
Employee Signature and Title

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES
CONSENT FOR TREATMENT

_____
INSTITUTION

Name: _____ TDOC ID: _____ Date of Birth: _____
Last First Middle

I hereby authorize _____ and assistants to perform the following operation, procedure,
(Practitioner)
treatment, or psychiatric intervention.

_____
Use Laymans Terms

The nature and extent of the intended operation, procedure, treatment, or psychiatric intervention has been explained to me in detail. I have been advised by _____ of the following
(Practitioner)
alternatives, if any, probable consequences if I remain untreated, risks and possible complications of proposed treatment as indicated:

_____
(Use Lavman's Terms)

I acknowledge that no guarantee or assurance has been made as to the result that may be obtained.

If any unforeseen condition arises in the course of the operation calling for the judgment of the practitioner for procedures in addition to or different from those now contemplated, I further request and authorize the practitioner to do whatever is deemed necessary.

I consent to the administration of anesthesia to be applied under the direction and supervision of _____.
(Practitioner)

I have read and fully understand the terms of this consent and acknowledge that the explanations referred to were made and that all blanks have been filled.

Date: _____ Time: _____ _____
(Signature of Patient)

Witness: _____ _____ _____
(Signature of Practitioner and Professional Title) Date

If the patient is a minor or incompetent to consent:

_____ Date: _____ Time: _____ a.m p.m.
(Signature of parent or person authorized to consent for patient)

Witness: _____ Witness: _____

TENNESSEE DEPARTMENT OF CORRECTION
MENTAL HEALTH TREATMENT PLAN

_____
INSTITUTION

INMATE: _____
TDOC ID: _____
DATE OF BIRTH: _____
GENDER: _____

TREATMENT PLAN REVIEW DUE ON: _____
☐ VOLUNTARY ☐ INVOLUNTARY ☐ LEVEL OF CARE
☐ INPATIENT ☐ OUTPATIENT
SPECIAL UNIT: SPECIFY: _____

LEVEL OF CARE: ☐ II ☐ III ☐ IV ☐ V

DSM-5 DIAGNOSIS:

TARGET SYMPTOMS/PROBLEMS:

1) _____
2) _____
3) _____
4) _____
5) _____

GOALS ACCORDING TO PROBLEM # ABOVE/INMATE RESPONSIBILITIES:

1) _____
2) _____
3) _____
4) _____
5) _____

TREATMENT MODALITY AND FREQUENCY TO ACHIEVE GOALS:

INMATE SIGNATURE / CONSERVATOR SIGNATURE	DATE
STAFF SIGNATURE TITLE	DATE
STAFF SIGNATURE TITLE	DATE
RECEIVING PROVIDER	DATE

TENNESSEE DEPARTMENT OF CORRECTION

PROBLEM ORIENTED – PROGRESS RECORD

INSTITUTION

INMATE NAME: _____ TDOC ID: _____

DATE	TIME	

Do Not Write on Back

NAME: _____ **NUMBER:** _____ **NO.**

DATE OUT	NAME & PHONE # OF PERSON WITH RECORD	DATE IN	DATE OUT	NAME & PHONE # OF PERSON WITH RECORD	DATE IN

SIGN IN/SIGN OUT FOR RECORDS

CR-1006 (Rev. 11/04)

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC ID _____

_____
INSTITUTION

SS# _____ **Gender** _____ **Age** _____ **D.O.B.** _____

Next of Kin: Name: _____ Relation: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: **Area Code** _____ **Number** _____

Date Completed: _____ Month _____ Day _____ Year

Height: _____ Weight: _____ Hair Color: _____ Color of Eyes: _____

Blood Pressure (Sitting): _____ Temp: _____ Pulse _____ Resp. _____

DATE, if done on Admission			
Serology		EKG	
Urinalysis		Chest X-Ray	
CBC		Hemoccult	
Chem. Scan			
Td Booster			
Other			

ALLERGIES: _____

Date or TB Skin Test _____

Date Read _____ Results _____ (Record in MM.)

Visual Acuity (Snellen) **R.** _____ **L.** _____

CURRENT MEDICATIONS: (Specify drug, strength, dosage form and frequency)

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC ID _____

1. Family History: Have any of your family or relatives had any of the following? If so, specify who:

Heart Disease	_____	Tuberculosis	_____	Cancer	_____
Sickle Cell	_____	Diabetes	_____	Seizures	_____
Hypertension	_____	Mental Illness	_____	Other	_____

Substance Use _____ Are your parents still alive? _____

2. Social History:

Highest Grade Completed _____ Usual Occupation _____ Marital Status _____

Previous Incarcerations _____ Old Number (TN, Other State, Federal) _____

Prior to Incarceration: _____

Used alcohol: Yes _____ No _____ If yes, Daily _____ Weekly _____ Rarely _____

Other habit forming drug(s) Yes _____ No _____ Daily _____ Social _____

Name(s) of Drug(s) _____

Ever injected drugs (even once)? Yes _____ No _____

3. When did you last see a doctor? _____

For What Reason: _____

4. Have you ever been told by a doctor that you now have or have had any of the following:
Answer questions by checking **yes** or **no**

YES		NO	COMMENT(S)
☐ a.	Rheumatic Fever	☐	
☐ b.	Heart trouble	☐	
☐ c.	High Blood Pressure	☐	
☐ d.	Thyroid trouble or Goiter	☐	
☐ e.	Diabetes	☐	
☐ f.	Kidney infections or Stones	☐	
☐ g.	Jaundice, hepatitis or liver disease	☐	
☐ h.	Ulcer	☐	
☐ i.	Pneumonia	☐	
☐ j.	Tuberculosis	☐	
☐ k.	Gallbladder Disease	☐	
☐ l.	Sexually Transmitted Infection/Disease (Venereal Disease)	☐	
☐ m.	Asthma	☐	
☐ n.	Emphysema	☐	
☐ o.	Anemia	☐	
☐ p.	Hemophilia	☐	
☐ q.	Cancer	☐	
☐ r.	Epilepsy or Seizure disorder	☐	
	Last seizure _____ Medication		
☐ s.	Allergies, (if yes, what? _____)	☐	
☐ t.	Any other serious illness, or injuries, operations or hospitalizations?	☐	
☐ u.	Any history of treatment in a Mental Health Clinic or Psychiatric Hospital?	☐	

☐ v. Any history of Substance Use Treatment either in or out patient? ☐ _____

Hospitalizations

DATE	NAME OF HOSPITAL	LOCATION	REASON

Surgical History

DATE	TYPE OF SURGERY	HOSPITAL/SURGICAL CTR	SURGEON

NO		YES	COMMENT(S)
5.			
☐ a.	Has there been any change in your weight in the past year? 1. Lost ☐ How much? _____ 2. Gain ☐ How much? _____	☐	_____
☐ b.	Have you ever had excessive anxiety/nervousness, depression or worrying?	☐	_____
☐ c.	Have you noticed a change in size or color of any wart or mole, or the appearance of a new one?	☐	
☐ d.	Any itching, skin rash or boils?	☐	_____
☐ e.	Do you use tobacco?	☐	
☐	1. Chew	☐	_____
☐	2. Pipe	☐	
☐	3. Cigars	☐	_____
☐	4. Cigarettes	☐	
	5. How many cigars, cigarettes, or pipes do you smoke in 24 hours? _____		_____
6.	**HEAD AND NECK**		
☐ a.	Do you have dizzy spells?	☐	_____
☐ b.	Do you have frequent headaches?	☐	
	How often? _____ What medicine helps your headaches? _____		_____
☐ c.	Do you have any lumps or swelling in your neck, armpits, groin or other areas?	☐	_____

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC ID _____

NO		YES	COMMENT(S)
7.	**EYES**		
☐ a.	Do you wear glasses or contact lens?	☐	
.	For how long? _____		
☐ b.	Do you see double?	☐	
☐ c.	Do you ever see colored halos around lights?	☐	
☐ d.	When your eyes were last examined?	☐	
☐ e.	Do you have trouble seeing objects at a distance or near objects such as a newspaper?	☐	
☐ f.	Do you have vision in both eyes?	☐	
8.	**EARS**		
☐ a.	Do you have difficulty hearing?	☐	
☐ b.	Have you had any earaches lately?	☐	
☐ c.	Do you have repeated buzzing or ringing in your ears?	☐	
☐ d	Do you have a hearing aid(s)?	☐	
9.	**MOUTH, NOSE AND THROAT**		
☐ a.	Do you have any trouble with your teeth or gums?	☐	
☐ b.	When did you last see a dentist?	☐	
☐ c.	Have you ever had sinus problems?	☐	
☐ d.	Does your nose ever bleed for no reason at all?	☐	
☐ e.	Is your voice more hoarse now than in the past?	☐	
10.	**RESPIRATORY**		
☐ a.	Do you have a chronic cough?	☐	
☐ b.	Do you cough up any material?	☐	
☐ c.	Ever have trouble getting your breath after climbing one flight of stairs or walking one city block?	☐	
☐ d.	Do you have frequent colds or influenza attacks?	☐	
☐ e	Do you have sleep apnea?	☐	
☐ f.	Do you use a CPAP/BiPAP Machine?	☐	
11.	**CARDIOVASCULAR**		
☐ a.	Ever get pains or tightness in your chest?	☐	
☐ b.	Ever been bothered by a racing heart?	☐	
☐ c.	Do you have shortness of breath while doing your usual work?	☐	
☐ d.	Need more pillows at night to breathe?	☐	
☐ e.	Do you have swollen feet and ankles?	☐	
☐ f.	Do you use a lot of salt on your food?	☐	
☐ g.	Do you have a pacemaker?	☐	
☐ h.	Do you have a defibrillator?	☐	

TENNESSEE DEPARTMENT OF CORRECTION

HEALTH HISTORY

Inmate Name: _____

TDOC ID _____

NO		YES	COMMENT(S)
12.	**DIGESTIVE**		
☐ a.	Do you suffer discomfort in the pit of your stomach?	☐	
☐	1. Nausea	☐	
☐	2. Vomiting	☐	
☐	3. Indigestion	☐	
☐	4. Heartburn	☐	
☐ b.	Is it painful or difficult for you to swallow liquids or solid foods?	☐	
☐ c.	Do you have trouble with bowel movements?	☐	
☐	1. Hemorrhoids	☐	
☐	2. Bleeding	☐	
☐	3. Constipation	☐	
☐	4. Diarrhea	☐	
☐	5. Bloody or Black Stools	☐	
☐	6. Rectal Pain	☐	
13.	**URINARY**		
☐ a.	Frequently get up at night to urinate?	☐	
☐ b.	Ever had burning or pains when urinating?	☐	
14.	**MUSCULOSKELETAL**		
☐ a.	Have stiff or painful muscles or joints?	☐	
☐ b.	Are your joints ever swollen?	☐	
☐ c.	Have you ever had any broken bones?	☐	
☐ d.	Have difficulty bending or moving?	☐	
15.	***SKIN***		
☐	Tattoos, piercings, lesions, ulcers, tags, moles, insect bites, rashes, or infections?	☐	
16.	***FOR MALES ONLY***		
☐ a.	Is your urine stream very weak and slow?	☐	
☐ b.	Has a doctor ever told you that you have prostate trouble?	☐	
☐ c.	Ever had discharge from your penis?	☐	
☐ d.	Do you have any pain, swelling, sores or lumps on your testicles or penis?	☐	
17.	***FOR FEMALES ONLY***		
☐ a.	Have you had a hysterectomy?	☐	
☐ b.	Are your menstrual periods regular? Date of last menstrual period: _____	☐	
☐ c.	Ever have pain with your periods?	☐	
☐ d.	Do you have excessive bleeding during your period?	☐	
☐	1. Between periods?	☐	
☐	2. After sexual relations?	☐	
☐	3. After going through the “change of life”?	☐	
☐ e.	What type of birth control method are you using? (Check appropriate)	☐	
☐	1. None	☐	

NO		YES	COMMENT(S)
☐	2. Birth control pills	☐	
☐	3. IUD (Loop)	☐	
☐	4. Foam	☐	
☐	5. Diaphragm	☐	
☐	6. Condoms	☐	
☐	7. Tubes Tied	☐	
☐	8. Other: _____		
☐	f. Do you have a discharge now?	☐	
☐	g. When was your last Pap Smear?	☐	
	_____		
☐	h. Ever had an abnormal Pap smear?	☐	
☐	i. How many times have you been pregnant? _____		
☐	1. Full term _____	☐	
☐	2. Premature _____	☐	
☐	3. Miscarriages _____	☐	
☐	4. Abortions _____	☐	
☐	5. Are you pregnant now?	☐	
☐	j. Do you examine you breasts regularly?	☐	
☐	k. Ever found any lumps in your breasts?	☐	
☐	l. Ever had discharge from your nipples?	☐	
☐	m. Have you had the Measles, Mumps, and Rubella Vaccine (MMR) as an adult?	☐	

I certify that the foregoing information supplied by me is true and complete to the best of my knowledge.

Date	Signature of Patient	Signature of Person Reviewing History