DEPARTMENT OF THE ARMY
LANDSTUHL REGIONAL MEDICAL CENTER
DEPARTMENT OF ORTHOPEDIC SERVICES & REHABILITATION
CMR 402 / CLINIC 10A/B
APO AE 09180

PATIENT INFORMATION

PATIENT NAME _____ DATE _____
LAST FIRST MI DD/MM/YY

REASON FOR VISIT (BODY PART AFFECTED):
_____

SEX: M / F AGE_____SPONSOR'S NAME _____ RANK _____
SPONSOR'S SSN _____ PCS/DEROS/ETS DATE _____UPCOMING DEPLOYMENT: Yes / No
MOS/AOC/AFSC _____ (CIVILIAN OR MILITARY) OCCUPATION TITLE _____

STATUS: Active Duty / Family Member / Civilian employee / DOD / Reserve / Retired
MARITAL STATUS: Married / Single / Divorced / Widowed

E-MAIL ADDRESS _____DUTY PHONE _____
SPONSOR'S DUTY STATION _____
CELL PHONE _____ HOME PHONE _____
SPONSOR'S UNIT _____
SUPERVISOR'S PHONE NUMBER (1SGT or CO) _____

Warrior Transition Unit (WTU)? Yes / No – If yes: Case managers' name and contact information: _____
_____

Medical Board (MEB) in progress? Yes / No – MEB Pending? Yes / No

ALLERGIES: None / Penicillin / Sulfa drugs / Latex / Other (list drug and reaction suffered):
_____
MEDICATIONS: None / (List all medications you are presently taking):
_____
_____

Are you enrolled in the Sole Provider program? Yes / No

Has there been any change in your health within the last year? If so, explain:_____
_____
Are you currently under the care of another physician? If so, explain: _____
_____
Do you have any pre-existing medical conditions (i.e. Diabetes, High blood pressure, etc.)? If so, list:

Have you ever had an operation? If so, list (with dates): _____
_____
Have you ever had a serious illness? If so, list: _____
_____
Are you pregnant? If so, how many weeks? _____

Do you use tobacco products? Yes / No Cigarettes Yes / No How many packs per day? ____ How long? _____
Other tobacco products?_____

Do you drink alcohol? Yes / No If yes, how many drinks and how often? _____