Reportable Medical Events System
Data Collection Form

Last Name:

First Name:

FMP

SocSec# — —

Date of Birth: M M D D Y Y Y Y

Address

State:

Zip:

Category:

Unit:

UIC:

Duty Phone: —

Race:
- O White
- O Black
- O American Indian
- O Asian
- O Hispanic
- O Other

Grade:

Sex:
- O Male
- O Female

Phone —

Diagnosis ICD-9 Code: .

Diagnosis Description

Reporting Site:

Date of Onset: M M D D Y Y

Admitted:
- O Yes
- O No

Admission Date: M M D D Y Y

Confirmed: O Yes O No O Pending

Method of Confirmation: O Slide O Clinical O Culture O Serology O Biopsy O Other

Malaria Chemoprophylaxis O Yes O No

Med1:

Med2:

O Yes O No

Pertinent Travel:

O Yes O No

Country1:

Country2:

Country3:

Comments:

FHT Form 350-X33, August 2005 (DACH)