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:
- ○ White
- ○ Black
- ○ American Indian
- ○ Asian
- ○ Hispanic
- ○ Other

Grade:

Sex:
- ○ Male
- ○ Female

Phone —

Diagnosis ICD-9 Code: .

Diagnosis Description

Reporting Site:

Date of Onset: M M D D Y Y

Admitted:
- ○ Yes
- ○ No

Admission Date: M M D D Y Y

Confirmed: ○ Yes ○ No ○ Pending

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

Malaria Chemoprophylaxis ○ Yes ○ No

Med1: **Med2:**

○ Yes ○ No

Pertinent Travel:

○ Yes ○ No

Country1: **Country2:** **Country3:**

Comments:

Date of Form: 11 MAY 2000