PROBLEM LISTS

PEDIATRIC SUMMARY OF CARE Name _____	Allergies _____ _____	MEDICAL GROUP LOGO
DOB _____		

ACUTE ILLNESS/HOSPITAL	CHRONIC ILLNESS	
	REFERRALS	DATE
	CHRONIC MEDICATIONS	
PAST HISTORY	FAMILY HISTORY	

SOCIAL HISTORY

Tobacco Yes ___ No ___ **Alcohol** Yes ___ No ___ **Substance Abuse** Yes ___ No ___

SCREENING	DATE	COUNSELING	DATE
IRON DEFICIENCY		SUBSTANCE ABUSE	
LEAD		DENTAL Health (after age 3)	
VISION		DIET / EXERCISE	
HEARING		UNINTENDED PREGNANCY / STD	
BLOOD PRESSURE (AGES 3 & OVER)		PREVENTION MOTOR VEHICLE INJURIES	
NEWBORN SCREENING		SEAT BELTS/LAP AND SHOULDER RESTRAINTS	
		IMMUNIZATION STATUS CHECKED	