PROBLEM LIST

Name: ______________________________

DOB: ______________________________

PROB #	PROBLEM	DATE	MEDICATION	DATE
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

SURGERY/PROCEDURE	DATE	ALLERGY	REACTION

PREVENTIVE HEALTH SCREENS													
Pap													
Mammogram													
Cholesterol													
Blood Pressure													
SOCIAL HISTORY													
Tobacco													
Alcohol													
Substance Abuse													
Other													
ADULT IMMUNIZATION													
Influenza													
Pneumoccoccal													
Hepatitis B													
Diptheria/Tetanus													
Rubella													