

NAME _____		DOB _____					
SUMMARY OF CARE							
DATE	CHRONIC ILLNESS/DIAGNOSIS	CHRONIC MEDICATIONS	START	STOP			
DATE	PAST MEDICAL HX	HEALTH MAINTENANCE	2007	08	09	10	11
		COMPLETED PHYSICAL EXAM					
		HEIGHT					
		WEIGHT					
		PAP SMEAR					
DATE	HOSPITALIZATIONS/SURGERIES	MAMMOGRAM					
		COLONOSCOPY					
		SIGMOIDOSCOPY					
		STOOL GUAIC					
		CHOL/LIPID					
DATE	SOCIAL HX/OCCUPATION	PSA					
		Td					
		INFLUENZA					
		PNEUMOVAX					
		GARDISIL					
DATE	FAMILY HX	HABITS (12 years and older)	2007	08	09	10	11
		TOBACCO					
		ALCOHOL					
		SUBSTANCE ABUSE					
		CAFFEINE					
ALLERGIES / ADVERSE REACTIONS		COUNSELING ITEMS (all ages)					
		SEAT BELT Yes <input type="checkbox"/> No <input type="checkbox"/>					
		SBE/STE Yes <input type="checkbox"/> No <input type="checkbox"/>					
		BIRTH CONTROL/STD					
		HORMONE REPLACEMENT					
		DIET					
		EXERCISE					

