

NAME _____						DOB _____							
<b>SUMMARY OF CARE</b>													
<b>DATE</b>	<b>CHRONIC ILLNESS/DIAGNOSIS</b>					<b>CHRONIC MEDICATIONS</b>			<b>START</b>	<b>STOP</b>			
<b>DATE</b>	<b>PAST MEDICAL HX</b>												
<b>DATE</b>	<b>HOSPITALIZATIONS/SURGERIES</b>												
<b>DATE</b>	<b>SOCIAL HX/EDUCATION</b>												
<b>DATE</b>	<b>FAMILY HX</b>												
<b>IMMUNIZATIONS</b>						<b>HEALTH MAINTENANCE</b>			2007	08	09	10	11
DtaP/Td						COMPLETE PHYSICAL EXAM							
DPT/HIB						HEIGHT							
HIB						WEIGHT							
Hep B/HIB						VISION SCREENING							
Hepatitis B						HEARING SCREENING							
OPV/IPV						INFLUENZA							
MMR						PNEUMOVAX							
Prevnar													
Varicella						<b>HABITS (12 years and older)</b>			2007	08	09	10	11
Chickenpox disease date						TOBACCO							
Gardasil						ALCOHOL							
<b>ALLERGIES / ADVERSE REACTIONS</b>						SUBSTANCE ABUSE							
						CAFFEINE							
						<b>COUNSELING ITEMS (all ages)</b>							
						CHILD SAFETY SEAT/SEAT BELT Yes <input type="checkbox"/> No <input type="checkbox"/>							
						DIET							
						EXERCISE							
						PAMPHLETS PROVIDED							