Medical Associates, P.A.

PROGRESS NOTES
PEDIATRIC

PATIENT'S NAME DATE SEX AGE

H.C.:

VITAL SIGNS: TIME: TEMP: BP: P: R: WT: HT: TAKEN BY:

SUBJECTIVE:

OBJECTIVE:

ASSESSMENT:

PLAN:

F/ U VISIT

DIET ( ) DIABETIC ( ) HIGH FIBER ( ) LOW FAT ( ) LOW SODIUM ( ) gm SODIUM ( ) CALORIES
( ) REGULAR ( ) RENAL ( ) ULCER ( ) OTHER

REFERRED TO_____ FOR FURTHER HEALTH EDUCATION ☐ YES ☐ NO RTC:

PROVIDER'S NAME: PROVIDER'S SIGNATURE:

PRIMARY CARE PHYSICIAN

Medical Associates, P.A.

PEDIATRIC INITIAL PHYSICAL

Name: _____

ID# _____ MR# _____

Age _____ Sex _____

Physician:

PATIENT NAME: _____ NO.: _____

VII. PHYSICAL EXAMINATION:

HEAD: _____ HEIGHT: _____ WEIGHT: _____ d.P _____ P. _____ R. _____ T. _____

GENERAL APPEARANCE: _____

HEAD: _____

EYES: _____

EARS: _____

NOSE: _____

TEETH: _____

THROAT: _____

NECK: _____

CHEST: _____

HEART: _____

ABDOMEN: _____

EXTREMITIES: _____

BACK: _____

GENITALIA: _____

SKIN: _____

NEUROLOGICAL: _____

VIII. DIAGNOSIS: _____

_____

_____

IX. STUDIES ORDERED: _____

_____

_____

X. TREATMENT PLAN:

A. MEDICATIONS: _____

B. DIET: REGULAR: _____ DIABETIC: _____ LOW FAT: _____ LOW SODIUM: _____ OTHER: _____

C. HEALTH EDUCATION: _____

D. REFERRED TO: _____

XI. RETURN VISIT: _____

XII. OLD CHART REQUESTED: YES☐ NO☐

DOCTOR: _____ HOSPITAL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____