

PEDIATRIC TREATMENT RECORD

Approved: 31 May 95

DATE	Appointment Time:	Timein:	Time Seen:
	Complaint:		
	Temp:	HR:	RR:
	Age:	Weight:	Height:
			FOC:
			PA:
	HPI:		
	Significant PMH:		
	Social Hx:		
	Current Medications:		
	Immunization Status:		
	Allergies:		
	PE:	<input type="checkbox"/> Normal	<input type="checkbox"/> Abnormal
		<input type="checkbox"/> Not examined	
	<input type="checkbox"/> General Appearance:		
	<input type="checkbox"/> HEENT:		
	<input type="checkbox"/> Neck:		
	<input type="checkbox"/> Resp:		
	<input type="checkbox"/> CVS:		
	<input type="checkbox"/> Abdomen:		
	<input type="checkbox"/> GU:		
	<input type="checkbox"/> Rectal:		
	<input type="checkbox"/> Neuro:		
	<input type="checkbox"/> Musculoskeletal:		
	<input type="checkbox"/> Skin:		
	<input type="checkbox"/> Other:		
	Treatment/Lab/X-ray:		

(Continued on reverse)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)

ID Card Checked	Y	N
Third Party Coverage	Y	N
EFMP Patient	Y	N
Medical Record Available	Y	N

