



MODERN CONCEPTS
Medical Group

Pediatric Progress Note

Physician:

Name:		D.O.B:		Date:	
Age:	HC:	T:	P:	R:	BP:
Allergies:		H:	W:	Birth Ht:	Birth Wt:

Nurse's Note:	LMP=
Medical Assistant Signature:	

COMPLAINT / ILLNESS:	DIET:
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PHYSICAL EXAM:

	NL	See note	Describe abnormal findings:
Gen Appearance:			
Skin:			
Head:			
Nodes:			
ENT:			
Lungs:			
Back:			
Heart:			
Abdomen:			
Ext. Gen.			
Neurological:			
Extremities:			
Musculoskeletal:			

Check Box if Test Requested:

<input type="checkbox"/> AUDIOMETRY (3yrs +)		
	Right	Left
250		
500		
750		
1000		
1500		
2000		
3000		
4000		
6000		
8000		

ASSESSMENT / PLAN:

VACCINES:
<input type="checkbox"/> DTaP # ____
<input type="checkbox"/> HIB # ____
<input type="checkbox"/> Hep B # ____
<input type="checkbox"/> IPV # ____
<input type="checkbox"/> MMR # ____
<input type="checkbox"/> Varicella
<input type="checkbox"/> PCV-7 # ____

<input type="checkbox"/> SNELLEN (3yrs +)
OD /
OS /
OU /

<input type="checkbox"/> HEMATOCRIT
(7-9mo, 13-15mo, 2+ yrs)
% <input type="checkbox"/> HCT
<input type="checkbox"/> HGB

TESTS:

U/A (4+ yrs) PPD (4 & 13yrs) Lead Level (10-12mo, 2yrs)

Guidance & Counseling
<input type="checkbox"/> Reviewed Sex, Cigarette use, and Drug use. Answered patients Ques.

Follow up:

Physician's Signature: _____