PEDIATRIC PROBLEM LIST AND CONTINUOUS USE MEDICATION LIST

PRIMARY LANGUAGE: _____

LANGUAGE PREFERENCE: _____

ALLERGIES:

INDICATE BY CHECK MARK THE FOLLOWING: DIABETES ☐ ASTHMA ☐ CCS ☐

CHRONIC / LONG STANDING PROBLEMS

DATE	PROBLEM

CONTINUOUS USE MEDICATION LIST

PATIENT NAME _____ BIRTHDATE _____

HOME PHONE _____ WORK PHONE _____

PHARMACY _____ PHARMACY PHONE _____

MEDICAL / ALLERGY ALERTS:

DATE RX	MEDICATIONS	ROUTE	DOSAGE	QTY.	FREQ.	REFILLS DATE AND INITIAL				STOP DATE