VEREEN
REHABILITATION CENTER

Wound Clinic Pediatric Medical History Form

Patient Name:_____ Date:_____

Sex: M / F Date of Birth:_____ Age:_____ Doctor:_____

Height: _____ Weight: _____ Form Completed By: _____

Relationship to Patient: _____ Person with Custody of Patient:_____

Emergency Contact: _____ Phone# _____

Allergies Medicine:_____ Food: _____

Latex: _____ Other: _____

Pharmacy:_____

Home Health Services? Yes / No Company Name:_____

Durable Medical Equipment? Yes / No Company Name:_____

Living Arrangements Lives With:_____ How many people live here? _____

Apartment_____ House_____ Air conditioning _____ Heat _____

Water: Well_____ City _____

Tobacco Smoking Around Patient? Yes / No

Drug or Alcohol Abuse in the Home? Yes / No

Any personal or religious beliefs we need to know about in planning our care? Yes / No

If Yes, explain:_____

Attends School or Daycare? Yes / No Name:_____ Grade:_____

Information on Adult Caring for Patient Last Grade Completed in School:_____

Primary Language: □ English □ Spanish Other _____

Problems With: □ Seeing □ Hearing □ Reading

Patient Medical History

Any problems at birth? Yes / No If yes, explain: _____

Premature: Yes / No Previous Hospitalizations: Yes / No Previous Surgery: Yes / No

Explain: _____

Any childhood diseases? Please explain:_____

Immunizations up to date? Yes / No

Any Problem with the Following: (Please circle all that apply)

Growth and development	Infections	Asthma	Cystic Fibrosis	Seizures
Kidneys, bladder, privates	Stomach or bowels	Heart	Circulation	Cancer
Muscles or Bones	Sickle Cell	Diabetes	Thyroid	
Skin disorders	Speech	Vision	Hearing	

Explain any problems:_____

_____

Function Does this patient walk? Yes / No Need help walking? Yes / No

Does this patient need help caring for themselves? Yes / No

Is Medical equipment needed? Yes / No Explain: _____

Nutrition Does this patient eat or drink regular food for their age: Yes / No

If not explain problem: _____

Any problems with appetite? Yes / No Chewing or swallowing? Yes / No

Explain: _____

Infant? Yes / No Formula: How many oz. per day? _____

Medication Does this patient take any medication daily? Yes / No

Name:	How Often:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Pain Is pain a problem at home? Yes/No What usually helps with pain?_____

What word does child use for pain?_____

Is there anything not mentioned above that we need to know concerning the patient's health?

_____

_____