CHILDREN'S HOSPITAL

Patient Form

Patient Information

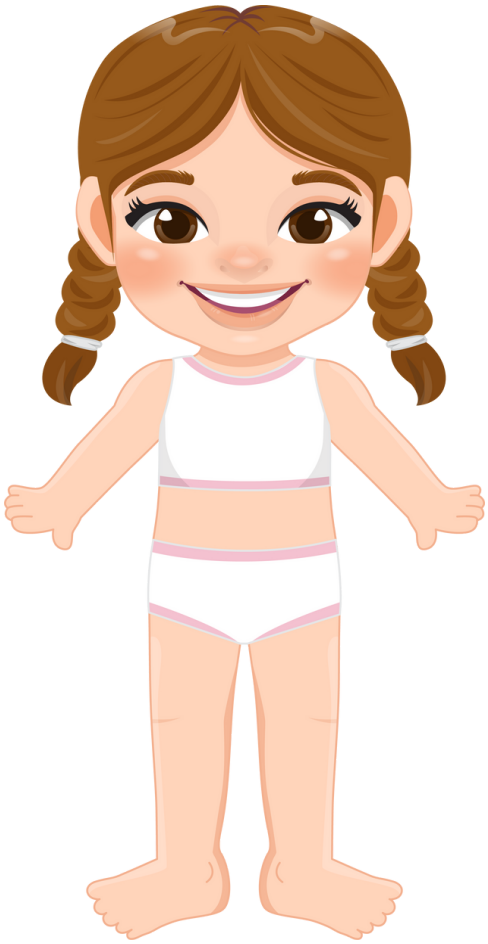
Name: _____ Age: _____

Height: _____ Temperature: _____

Weight: _____ Heart Rate: _____

Symptoms

Circle where it hurts:



Pain scale:

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