Pediatric Healthcare
of Long Island

Patient Name _____ Date of Birth _____ / _____ / _____ Phone ( ) _____ - _____

Place a check next to any symptom that has been a frequent or severe problem for the patient.

Constitutional

□ Body aches □ Fatigue □ Loss of appetite
□ Chills □ Fever □ Unexpected weight loss

Head, Ears, Eyes, Nose, Throat

□ Difficulty hearing □ Nasal congestion □ Swollen glands
□ Ear pain □ Sore throat

Cardiovascular

□ Chest pain □ Fainting □ Irregular heart beat

Respiratory

□ Coughing □ Difficulty breathing □ Shortness of breath

Gastrointestinal

□ Abdominal pain □ Diarrhea □ Trouble swallowing
□ Constipation □ Heartburn □ Vomiting

Neurologic

□ Dizziness □ Headaches □ Seizures

Musculoskeletal

□ Back pain □ Joint pain □ Joint swelling

Heme-Lymph

□ Easy bleeding □ Easy bruising □ Swollen glands

□ Check here is the patient has none of the complaints/symptoms on the form

Patient's Past Medical History

Place a check next to any condition the patient has had:

□ Check here if the patient has had none of the condition

□ Anemia □ Celiac Disease □ Heart Disease □ Hypothyroidism □ Pneumonia
□ Arthritis □ Colitis □ Hematological Disorder □ Irritable Bowel Syndrome □ Seizure Disorder
□ Bronchitis □ Diabetes Mellitus □ Hormone Disorder □ Kidney Disease □ Smoking
□ Cancer □ Gastrointestinal Disorder □ Hyperthyroidism □ Lung Disease □ Stroke
□ Cataract

Other:_____

Patient's Past Surgical History

□ Check here if the patient has never had surgery

Please list any surgical procedures the patient has had

_____

_____

Patient's Medications

List any medications the patient is taking:

_____

_____

Patient's Allergies

List patient's allergies: or □ NO KNOWN ALLERGIES

_____

_____