Kidz Now Urgent Care

Patient Name____DOB________________Date_____________

Child Past Medical History: *(If yes, specify)*			**FAMILY MEDICAL HISTORY (IF YES, WHOM)**		
DERM DISORDERS	NO	YES________________	HEART DISEASE:	NO	YES __________________
EYE DISORDERS	NO	YES________________	DIABETES:	NO	YES __________________
EAR/NOSE/THROAT DISORDERS	NO	YES________________	CANCER:	NO	YES __________________
ALLERGIES	NO	YES________________	THYROID:	NO	YES __________________
RESPIRATORY DISORDERS	NO	YES________________	KIDNEY DISEASE:	NO	YES __________________
CARDIAC DISORDERS	NO	YES________________	ASTHMA:	NO	YES __________________
GI DISORDERS	NO	YES________________	LUNG DISEASE:	NO	YES __________________
KIDNEY DISORDERS	NO	YES________________	LIVER DISEASE:	NO	YES __________________
UROLOGICAL DISORDERS	NO	YES________________	BLEEDING DISORDERS:	NO	YES __________________
ENDOCRINE DISORDERS	NO	YES________________	GI DISORDERS:	NO	YES __________________
RHEUMATOLOGY DISORDERS	NO	YES________________	HIV:	NO	YES __________________
GENETIC DISORDERS	NO	YES________________	SEIZURES:	NO	YES __________________
ORTHOPEDIC DISORDERS	NO	YES________________	NEUROLOGIC DISORDERS:	NO	YES ________________
HEMATOLOGIC DISORDERS	NO	YES________________	PSYCHIATRIC DISORDERS:	NO	YES ________________
IMMUNOLOGIC DISORDERS	NO	YES________________	ADD/ADHD:	NO	YES ___________________
NEUROLOGIC DISORDERS	NO	YES________________	BIRTH DEFECTS:	NO	YES ___________________
PSYCHIATRIC DISORDERS	NO	YES________________	ALLERGIES:	NO	YES ___________________
Other remarkable past history:______________________			HYPERTENSION:	NO	YES____________________
			Other remarkable past history:_____________________		

Prior Hospitalization History:		***Surgical History:***	
1. ***Hospitalization History NO YES***		***Surgical History NO YES***	
2. Orbital Cellulitis____	Jaundice___	Head & Skull Surgery___	Other:__________________
3. Peritonsillar Abscess____	Failure to thrive___	Eye Surgery___	
4. Retropharyngeal Abscess___	Over Dose___ Intentional___	ENT Surgery___	
5. Asthma___	Eating Disorder___	Ear Tubes___	
6. Bronchiolitis___	Substance Abuse___	Adenoidectomy___	
7. Pneumonia___	Other:_________________	Tonsillectomy___	
8. Influenza___		Oral Surgery___	
9. Pleural Effusion___		Cardiothoracic Surgery___	
10. Dehydration___		Heart Surgery___	
11. Gastroenteritis___	Date of Hospitalization:________	Abdominal Surgery___	Date of Surgery:____________
12. Rotavirus___	Reason:___________________	Appendectomy___	Reason:___________________
13. Abdominal Pain___	_________________________	Inguinal Hernia Repair___	_________________________
14. Headache___	_________________________	Kidney Surgery___	_________________________
15. Concussion___	Date of Hospitalization:_______	Urologic Surgery___	Date of Surgery:____________
16. Febrile Seizure___	Reason:___________________	Circumcision Surgery___	Reason:____________________
17. Epilepsy___	_________________________	Hypospadias Surgery___	_________________________
18. Fracture___	_________________________	Orthopedic Surgery___	
19. Osteomyelitis___		Knee Surgery___	