Associates in Family Medicine
M. Michelle Hamidi, MD

Pediatric/Adolescent Medical History

Child's Name ____________________ Nickname: ________________ DOB: _________ Grade: ______

Mother's Name __________________ Occupation: ______________ Phone #: ______________

Father's Name __________________ Occupation: ______________ Phone #: ______________

Are the child's parents ___ Married ___ Unmarried ___ Separated ___ Divorced

Are there any siblings at home? YES NO Please list ages: ____________________________________

This child lives with: __Mother & Father __Mother Only __Father Only __Other: ________________

Is there anyone else that lives at home with this child? ____

Does your child attend daycare? _______ Primary language spoken at home________________

Who takes care of the child during the day or after school? ______________________________________

Child's Health History

Birth weight? ____________ Please circle: Term Pre-term Post term

Is child adopted? YES NO

Complications with pregnancy? YES NO

Hospitalizations immediately after birth? YES NO

Has child missed any immunizations? YES NO

Has your child ever had surgery? YES NO

Other hospitalizations? YES NO

Any problems with recurring illnesses? YES NO

Any hearing, vision or other disabilities? YES NO

Any concerns about your child's development? YES NO

Any concerns about your child's behavior? YES NO

Has your child ever been seen by a specialist? YES NO

If yes to any of the above questions, please explain

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Does your child have any ALLERGIES to any medications, foods, or other materials? YES NO

If yes, to what? ____

List all medications your child takes (include over the counter meds, vitamins and inhalers)

NAME/DOSE OF MEDICATION	REASON FOR TAKING MEDICATION

FAMILY HISTORY

Does anyone in the family have any history of the following?
Please list mother, father, maternal/paternal grandmother/grandfather, sibling

High blood pressure	YES	NO	WHO? ________________
High cholesterol	YES	NO	WHO? ________________
Heart disease	YES	NO	WHO? ________________
Stroke	YES	NO	WHO? ________________
Diabetes	YES	NO	WHO? ________________
Thyroid disease	YES	NO	WHO? ________________
Cancer	YES	NO	WHO? ________________
Bleeding/clotting disorder	YES	NO	WHO? ________________
Allergies	YES	NO	WHO? ________________
Asthma	YES	NO	WHO? ________________
Liver disease	YES	NO	WHO? ________________
Kidney disease	YES	NO	WHO? ________________
Seizures	YES	NO	WHO? ________________
Migraines	YES	NO	WHO? ________________
Acid reflux	YES	NO	WHO? ________________
Gastrointestinal disease	YES	NO	WHO? ________________
Mental problems	YES	NO	WHO? ________________
Alcohol problems	YES	NO	WHO? ________________
Drug problems	YES	NO	WHO? ________________
Genetic disorders/Birth defects	YES	NO	WHO? ________________
Autism	YES	NO	WHO? ________________

Safety/Prevention

Does your child wear a seat belt?	YES	NO	
Does your child use a car seat?	YES	NO	N/A
Does your child sit in the back seat?	YES	NO	
Does your child wear protective headgear during certain activities?	YES	NO	
Does your child receive regular dental care?	YES	NO	
Do you having working smoke detectors at home?	YES	NO	
Are there any firearms in the home?	YES	NO	
Is violence at home a concern?	YES	NO	
Is your child exposed to any second-hand smoke?	YES	NO	
Are there any pets at home?	YES	NO	

Do you have any other concerns about your child? ________________________________

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