

**CHARLES HENDERSON CHILD HEALTH CENTER  
NEW PATIENT QUESTIONNAIRE**

**OP NUMBER \_\_\_\_\_  
MD NUMBER \_\_\_\_\_**

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**CHILD'S PAST MEDICAL HISTORY**

**PLEASE INDICATE YES OR NO IF YOUR CHILD HAS OR HAS HAD ANY OF THE FOLLOWING**

CONDITION	YES	NO	EXPLANATION
SERIOUS INJURIES OR ACCIDENTS			
SURGERIES			
EMERGENCY ROOM OR OVERNIGHT HOSPITALIZATIONS			
CHICKEN POX			IF YES, AT WHAT AGE?
FREQUENT SORE THROATS OR TONSILLITIS			
FREQUENT EAR OR SINUS INFECTIONS			
OTHER INFECTIONS			
SEEN A DOCTOR FOR PROBLEMS WITH CONSTIPATION			
PROBLEMS WITH BLADDER OR KIDNEY INFECTIONS OR OTHER PROBLEMS URINATING			
BEDWETTING AFTER THE AGE OF 5 YEARS			
EYE PROBLEMS FOR WHICH S/HE HAS SEEN A DOCTOR			
EAR PROBLEMS OR PROBLEMS WITH HEARING			
SKIN PROBLEMS (EXAMPLES ACNE OR ECZEMA)			
ANEMIA, BLEEDING PROBLEMS OR CANCER			
BLOOD TRANSFUSION			
SEIZURES, DEVELOPMENTAL DELAYS, ATTENTION DEFICIT DISORDER (ADD/ADHD) OR NEUROLOGICAL/BRAIN PROBLEM			
FREQUENT HEADACHES			
MENTAL HEALTH/EMOTIONAL CONCERNS (EXAMPLE- DEPRESSION, ANXIETY)			
PROBLEMS WITH HIS/HER BONES (EXAMPLE- BROKEN BONES, ARTHRITIS)			
PROBLEMS WITH DIABETES			
THYROID OR HORMONE PROBLEMS			
ALLERGIC RUNNY NOSE OR OTHER ALLERGIES (EXAMPLE-FOOD ALLERGIES)			
OUTDOOR ALLERGIES			
INDOOR ALLERGIES			
ASTHMA, BRONCHITIS, BRONCHIOLITIS, PNEUMONIA OR CROUP			
HEART PROBLEMS OR HEART MURMUR WERE THEY SEEN BY A SPECIALIST OR HAD TESTS DONE?			
STOMACH PAIN OR ACID REFLUX/HEARTBURN			
ANIMALS INSIDE OR OUTSIDE THE HOME			
HISTORY OF ALCOHOL OR DRUG USE			
FEMALE: HAS PERIODS STARTED ANY PROBLEMS WITH PERIODS?			IF YES, AT WHAT AGE? IF YES, EXPLAIN:
LIST ALL OTHER SIGNIFICANT PROBLEMS:			

**SOCIAL HISTORY**

1. What adults live with the child? \_\_\_\_\_  
\_\_\_\_\_
2. Who has custody of the child? \_\_\_\_\_
3. Does the noncustodial parent have visitation? YES \_\_\_ NO \_\_\_  
If yes, what is the visitation schedule? \_\_\_\_\_
4. List all siblings in the home? \_\_\_\_\_  
\_\_\_\_\_
5. Are there siblings that live in another home? YES \_\_\_ NO \_\_\_
6. Are there pets inside or outside the home? YES \_\_\_ NO \_\_\_
7. Is your child exposed to smoke inside or outside the home? YES \_\_\_ NO \_\_\_
8. Are there guns in the home? YES \_\_\_ NO \_\_\_  
If yes, are all guns locked up and away from ammunition? YES \_\_\_ NO \_\_\_

**FAMILY HISTORY**

**PLEASE INDICATE ANY ISSUES IN RELATION TO THE PATIENT AND LIST THE RELATIVE**

CONDITION	RELATIVE- MOTHER'S SIDE	RELATIVE- FATHER'S SIDE
HIGH CHOLESTEROL		
HEART DISEASE/HEART CONDITION		
ASTHMA/LUNG PROBLEM		
HIGH BLOOD PRESSURE		
DIABETES, THYROID/ENDOCRINE PROBLEM		
CANCER		
ANEMIA (LOW BLOOD COUNT)		
BLOOD DISORDERS		
SEIZURE DISORDER		
DEVELOPMENTAL DISABILITY		
ADHD, ANXIETY, DEPRESSION OR MENTAL ILLNESS		
STOMACH OR DIGESTIVE PROBLEMS		
LIVER DISEASE		
KIDNEY DISEASE		
CHILDHOOD HEARING PROBLEMS		
IMMUNE SYSTEM PROBLEMS		