NEW PATIENT QUESTIONNAIRE FOR CHILDREN

Please fill in this questionnaire for your child and hand it in with their registration form

Name:		Date of Birth	
Address:			
Postcode		Telephone Number	

MEDICAL HISTORY

Is your child currently in good health? ☐ Yes ☐ No

If no please specify_____

Is your child currently taking any medication? ☐ Yes ☐ No

If yes please specify _____

Did your child suffer any complications at birth? ☐ Yes ☐ No

If yes please specify _____

Has your child had any serious illness in the past or ever been in hospital? ☐ Yes ☐ No

If yes please specify _____

Has your child ever had any allergies? ☐ Yes ☐ No

If yes please specify _____

IMMUNISATIONS

Has your child received the following immunisations?

If possible please give the dates of immunisations and delete any immunisations not received

	1st	2nd	3rd
Diphtheria, Tetanus, Whooping Cough			
Polio			
HIB			
Meningitis			
MMR (age 12 – 15 months)			

	Pre school booster	Booster	Booster
Diphtheria and Tetanus			
Polio			
MMR			

Any other immunisations (eg holiday) _____

Date _____/_____/_____

FAMILY HISTORY

Is there any history in the family of :			
☐ Diabetes	☐ Asthma	☐ Heart Disease	☐ Stroke
☐ Epilepsy	☐ Cancer	☐ High Blood pressure	
If so please specify relationship		Age the relation contracted this	

If your child takes medicines regularly please attach the right hand side of your prescription to this registration form.