NEW PATIENT QUESTIONNAIRE

CHILD **Private & Confidential**

Surname: …….. Forenames: ……

Date of Birth: …….. Ethnic Origin……..

Address: ……

Post Code…….. Tel No (home): ……..

Tel No (work)……..

E-mail: …….. Tel No (mobile): ……..

Name of carer/contact in case of emergencies:…….. Tel no: ……

Parents / guardians name(s) ……

Personal Medical History

Has your child had any of the following illnesses? (Please circle any that apply)

Asthma **Epilepsy** **Diabetes** **Cancer**

Please enter details of these and any other significant chronic illnesses, operations or disabilities including any on-going specialist care:

Year	Details		Year	Details

Drugs & Medicines

(If a child is receiving medication a doctors appointment must be made before getting new supplies)

Is your child taking any drugs, medicines or tablets? **YES / NO** If **yes**:

Name of the medicine	Dose	Reason for taking

If your child is under 18 months of age please can you answer the following question:

When your child was 6 months feeding was:

Breast Fed Totally **YES / NO**

Breast & Bottle Fed **YES / NO**

Bottle Fed **YES / NO**

If you know the date of the six-week check please write it here ……

Allergies

Is your child allergic to any tablets or substances **YES / NO** If **Yes**, please give details

Substance child is allergic to	Nature of the reaction (e.g. rash, collapse, swelling etc)

Childhood Vaccinations

Please could you enter the dates of any childhood vaccinations your child has already received:

			Date	Date	Date
Baby Jabs	Hib	1	2	3
	Diptheria	1	2	3
	Tetanus	1	2	3
	Pertussis	1	2	3
	Men C	1	2	3
	Polio	1	2	3
Hib Catch up	Hib	4		
MMR		1		
Pre-school	Diptheria	4		
	Tetanus	4		
	Pertussis	4		
	Polio	4		
	MMR	2		
Others				

Influenza Vaccination

We run an **influenza** vaccination programme every September/October for all patients in high risk groups (asthma, diabetes, chronic heart, kidney and liver disease and those immunocompromised).

If your child is in a high-risk group do you wish him / her to be invited for an influenza vaccination? YES NO

Family History Please indicate if any relatives have suffered from any of the following conditions

Cancer	NO	YES	Who & details	
Diabetes	NO	YES	Who & details	
Asthma	NO	YES	Who & details	
Heart Disease	NO	YES	Who & details	
Stroke	NO	YES	Who & details	
Hereditary & other significant diseases	NO	YES	Who & details	

Signature: …… Date: ……