HANWAY MEDICAL PRACTICE

CHILDREN'S NEW PATIENT QUESTIONNAIRE (Under 14's)

First Name (s) : .....

Surname: .....

Address: .....

.....

Previous address: .....

Date of Birth: ..... Tel No: .....

School: .....

Mothers full name: .....

Fathers full name: .....

If under Guardianship please give full name and relationship of Guardian (e. Grandparent):

.....

CHILD'S MEDICAL HISTORY

Has your child ever had? Measles Mumps German Measles Whooping Cough

Has your child had any serious illness or injury ? YES / NO

If yes please give details:

Has your child suffered from any infectious diseases? YES / NO

If yes please give details:

Does your child have asthma, eczema or hay fever? YES / NO

If yes please give details:

Is your child on any regular medication? YES / NO

If yes please list:

Is your child allergic to any substances (ie. Medications, plasters etc)? YES / NO

If yes please give details:

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IMMUNISATION HISTORY

PLEASE BRING YOUR CHILD DEVELOPMENT BOOK WITH YOU TO YOUR APPOINTMENT

Please tick all the listed vaccinations that your child has had:

- 2 months - DTaP, IVP, Hib & PCV & Rotavirus
- 3 months - DTAP, IVP, Hib & Men C & 2nd Rotavirus
- 4 months - DTaP, IVP, Hib, PCV
- 12/13 months - Hib/Men C (booster) PCV booster & 1st MMR
- 3 years 4 months and over: DTaP, IVP and 2nd MMR
- 13 years and over: DTP & Men C booster

Additional vaccinations that may have been given:

BCG Hepatitis B Hepatitis A

TO BE COMPLETED BY HCA

BP: ..... URINE: .....

WT: ..... HT: .....

I.D SEEN YES / NO (take a photocopy of documents and attach to the form)

SIGNATURE: .....