CHILDREN’S NEW PATIENT QUESTIONNAIRE

As your child is under 15 years of age we would be grateful if you could please complete the following questionnaire in order to give a brief medical history as it may take some time to receive their original medical records. This will be confidential and included in their medical records.

**Child’s Personal Details**

Name ……………………………………… Date of Birth ……………… Postcode …………………

Telephone no (home) …………………….. Mobile:……………………

**Name of next of kin/emergency contact details:**

Name of person……………………………… Their relationship to child ………….……………………….

Their contact telephone number/s: ….……….………………………………….…………………………………

Their address (inc postcode please): …………………………………………………………………........................

Weight ……………………………..kg Height ………………………………...………...cm

Has your child ever been given advice on diet? YES/NO

If yes was this for: High Fibre diet YES/NO

 Diet for medical reasons YES/NO

 Referred to a dietician YES/NO

Does your child take regular exercise? None at all light moderate heavy

**Medical History:** Please list, with date and year, any serious mental or physical illness or childhood diseases:

 Illness: …………………………….…………………………………………………………………………

 ……………………………………………………………………………………………………………

 Operations: …………………………………………………………………………………………………...

 ……………………………………………………………………………………………………………

 Injuries: ………………………………………………………………………………………………………

 ……………………………………………………………………………………………………………

Is your child on any regular medications? (Please list tablets and/or other prescription items) ……………………

 …….………………………………………………………………………………………………………………

Does your child have any allergies, eg. Penicillin? (please specify) ……………………………………………..…

**Vaccinations:**

Has your child had any of the following vaccinations. If yes, please give dates where possible.

Dip/Tet/Whooping cough (Triple) YES/NO Date …………………………..

Polio YES/NO Date …………………………..

HIB (Meningitis) YES/NO Date …………………………..

MMR YES/NO Date …………………………..

Diptheria/Tetanus/Polio (Pre-school booster) YES/NO Date …………………………..

Rubella YES/NO Date …………………………..

MMR booster YES/NO Date …………………………..

**Your signature …………………………………………………………… date ……………………………**

**Leaflets are available on request from reception on Immunisations, Healthy Eating and Exercise**