Which of the usual childhood illnesses has your child had? *(e.g. measles, mumps,*

*chickenpox, etc.) …………………………………………………………………………*

*………………………………………………………………………………………………*

………………………………………………………………………………………………

Is your child currently under any hospital? *YES / NO* If yes, why and which

hospital? ......................................................................................................................

Does your child currently take any regular medication?  *YES / NO* If yes, please list

any drugs, medicines or tablets: ……...................................…....................................

Does your child have any allergies? *YES / NO*

If yes, please list: .........................................................................................................

***Family medical history***

Please underline or circle if any close relative has suffered from any of the following

and state which family member

*Problem Family member Problem Family member*

Epilepsy ..................................... Diabetes .....................................

Hay fever ..................................... Blindness/glaucoma .............................

Stroke ..................................... Asthma .....................................

Heart attack ..................................... Eczema .....................................

Blood pressure ..................................... Sudden death .....................................

Thyroid problems .................................. Mental illness .....................................

Cancer (if yes, of which part of the body?) ..........................................................

***Social history***

What school does your child attend?…………………………………………………..

……………………………………………………………………………………………..

Does your child have problems with learning? *YES / NO*

What are the occupations of: Father…………………….Mother…………………….

What type of accommodation do you have? …………………………………………

***Medical history***

Was your pregnancy with this child normal? *YES / NO* If not, what happened?

……………………………………………………………………………………………

Where did you have the child?………………………………………………………..

Please list any serious or ongoing illnesses, operations or disabilities with dates

*Problem Date Problem Date*

................................................. .......... ................................................. ..........

................................................. .......... ................................................. ..........

Please underline or circle if your child has ever suffered from of any of the following

*Problem Details Problem Details*

Epilepsy ..................................... Diabetes .....................................

Hay fever ..................................... Hearing loss ……..............................

Fractures ..................................... Asthma .....................................

Eczema ..................................... Cancer .....................................

(if yes, of which part of the body?)

***Immunisations***

IMPORTANT : Please provide a copy of the RED BOOK, a record of past immunisations, or complete the following immunisation table with approximate dates for your child

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 1st | 2nd | 3rd | Where given? |
| Diphtheria, Tetanus, Pertussis, Polio, Hib *(3 doses at approximately 2, 3 and 4 months)* |  |  |  |  |
| Meningitis C  *(3 doses at approximately 2, 3 and 4 months)* |  |  |  |  |
| MMR  *(Single dose at approximately 1 year)* |  | TICK OR  DATE  WHERE  APPLICABLE | |  |
| Pre-school booster  *(Single dose at approximately 4 years)* |  |  |
| MMR 2  *(Single dose at approximately 4 years)* |  |  |
| BCG |  |  |
| Leavers school booster  *(Single dose at approximately 15 years)* |  |  |

**CHILDREN OVER 5 YEARS OLD ARE ENTITLED TO A REGISTRATION CHECK WITHIN 28 DAYS OF REGISTERING – DO YOU WISH TO TAKE ADVANTAGE OF THIS CHECK? *YES / NO***

***Health details*** *(to be completed at registration check)*

Height: ..................….... Weight: .............…..... Any special diet? ...........................

BP (10yrs+)……………………………….



Parent/Guardian signature: .............................................. Date: ..........................................

#### Revised January 2008

- CHILD PATIENT QUESTIONNAIRE -

Please do not be offended by the questions in this questionnaire. They will be useful to the Doctor

as they may affect your child’s health. All information is treated confidentially within the surgery.

If there is anything you do not understand please ask at the reception desk.

###### Personal details

Surname: ……………….......………….........................….………………………Male/Female

First Names: ………….…................................…………….Date of Birth: ..............……......…..

Address:.................……….................................................………………………………………..

............................................................................…………............... Postcode: ........................

Mothers name……………………………………………………………….………………………….

Fathers name………….…….………………………………………………………………………….

Contact telephone – Home: ..................…….................…………...……………………………...

Work(s): Mother..…...............………………………Father……….………………………………..

Mobile(s): Mother.……………………………………Father.……........................…….................

Name & tel. no. of child’s primary carer? *(if not parent)* *.……………………….……………*

*Do we have your consent to contact you on any of these telephone numbers and if necessary leave a*

*message?* YES/NO

NHS No (if known).: ………………………………….........…………....................................…....

Is this the first time your child has registered with an NHS GP? *YES / NO*

Has your child ever been a patient at this surgery? *YES / NO*

Is this child one oftwins? *YES/NO*

Town and Country of Birth: (*if a UK town/city, what district? e.g. Camden, Brent*

*etc*.) ..........................................If not UK, what date did they arrive? .......…...........

Is the child a refugee? YES / NO Do they live in a hostel? YES / NO

Child’s ethnic category (*e.g. British, African, Asian etc.)* …………………………………

Child’s first language? ........................................................BSL? YES/NO

*(British sign language)*

Do they speak any English? *YES/NO* Do they need an interpreter? *YES/NO*

***Practice use only***

Proof of residency seen: YES / NO EMIS number: ................................ Signature Nurse/HCA………………………….Date………………………………….