New Patient Health Questionnaire – UNDER 16 YRS

Surname: ………………………………Forename(s):………………………………………

Date of Birth: …../....../...... Sex: Male tick box Female tick box

Parent/Guardian Name: ………………………………………………………………

Home Tel:………………………….... Mobile Tel……………………………….

School/Nursery attended………………………………………………………………

MEDICAL HISTORY

Does this child have any of the following? (Please tick and include details)

ALLERGIES …………………………………………………………….

MEDICATION ALLERGIES …………………………………………………………….

ASHTMA …………………………………………………………….

DIABETES …………………………………………………………….

Other SERIOUS ILLNESS …………………………………………………………….

Is this child currently under the care of a Hospital or attending other clinics?

(If yes, please indicate which Hospital and brief details)

………………………………………………………………………………………………

……………………………………………………………………………………………

Do you have any concerns regarding your child’s’ health?

If yes please detail……………………………………………………………………………….

Is this child on any regular medication? – If yes please list including strength & dose

……………………………………… ………………………………………

……………………………………… ………………………………………

……………………………………… ………………………………………

FAMILY HISTORY

Has any close family had any of the following (please specify family member):

Diabetes…………………………… Asthma……………………………………

Heart Disease…………………….. High Blood Pressure…………………..

Stroke……………………………… Tuberculosis…………………………….

Eczema……………………………. Migraine…………………………………..

Cancer (please specify type)........................................................................................

YOU WILL NEED TO PROVIDE DETAILS OF ALL CHILDHOOD IMMUNISATIONS

Have you handed in the Red book/Documentation of immunisations? tick box

**Updated 02.05.2017**