

**NEW PATIENT QUESTIONNAIRE – CHILDREN**  
(up to & including 15 years of age)

Name:

Tel. No:

Date of Birth:

Address:

Parent(s)/Guardian(s) Names

First Parent/Guardian:

Second Parent/Guardian:

**MEDICAL HISTORY**

1. Has your child had any major illnesses (e.g. pneumonia) or does he/she suffer from any longer term illness (e.g. asthma, diabetes) ?

2. Has he/she had any operations ?

3. Does he/she take any medications ? Please note name, dosage and when taken:

4. Does he/she have any allergies (e.g. to Penicillin) ?

5. Has he/she had the following immunisations ?

|                                 |                     |
|---------------------------------|---------------------|
| Diphtheria/tetanus/polio        | (3 or more doses) ? |
| Whooping cough                  | (3 doses) ?         |
| Measles                         | (1 dose) ?          |
| B.C.G                           | (1 dose) ?          |
| M.M.R. (Measles, Mumps, Rubella | (1 dose) ?          |
| Rubella (German measles)        | (1 dose) ?          |
| Hib                             | ?                   |

6. Are there any problems or information not referred to above which you would like your child's doctor to know?

7. Children up to the age of 5 years may be due a general check at 6 months old, 8 months old, Pre-school/4 - 5 years old.

Would you like this to be done at this surgery?

Next of kin to be contacted in emergency

|                       |  |                  |  |
|-----------------------|--|------------------|--|
| Name (Block Letters): |  | Home Tel Number: |  |
| Address:              |  | Mobile Number:   |  |
|                       |  |                  |  |
|                       |  |                  |  |