CHILDREN'S QUESTIONNAIRE

Please complete as many questions as you can about your child. The information will help the practice to provide better medical care for your family.

Today's Date: …………………..

Child's Surname: ………………. Parent's Surname: ……………. Tel: No.: …………...

Child's First Name: …………………………………………… Date of Birth: …………...

Next of Kin: ……………………………………………………

Relationship of Next of Kin ……………………………………….

Is your Next of Kin Registered with this Practice? Yes/No

Contact Details of Next of Kin ………………………………………………………………………..

School: …………………………………………………………………………………………….

ETHNICITY: (Please circle)

British/Mixed British
Irish
Other White
White and Black Caribbean
White and Black African
White and Asian
Other Mixed
Indian British
Pakistani/British Pakistani
Bangladeshi/British Bangladeshi
Other Asian
Caribbean
African
Other Black
Chinese
Other

FIRST LANGUAGE SPOKEN

English Yes/No, If No, please give details ……………………………………

MEDICATION

Is your child on any regular medication? YES/NO

If YES, please give details: ………………………………………………………………………

ALLERGIES

Is your child allergic to any drugs? YES/NO

If YES, please give details: ……………………………………………………………………..

Does your child suffer from any other allergies? YES/NO

If YES, please give details: ……………………………………………………………………

SPECIAL NEEDS

Does your child have any hearing or eyesight problems? YES/NO

If YES, please give details: ……………………………………………………………………………..

Does your child have any special educational needs? YES/NO

If YES, please give details: ……………………………………………………………………………..

HOSPITAL WAITING LISTS

Is your child on a hospital waiting list, awaiting treatment? YES/NO

If YES, please give details as follows: Hospital: ……………………………………

Consultant: …………………………..…….. Treatment: ………………………………………………

Date on Waiting List: …………………………(Please give an approximate date if you do not have an exact one.)

CHILD'S MEDICAL HISTORY

Were there any important complications in the birth of your child? YES/NO

If YES, please give details: ……………………………………………………………………………..

Has your child had any of the following: (Please tick and give an approximate date.)

	Tick	Date		Tick	Date
Asthma			Measles		
Chicken Pox			Mumps		
Fits			Whooping Cough		
German Measles					

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

If YES, please give details: ……………………………………………………………………………..

Has your child ever been admitted to hospital? YES/NO

If YES, please give details: ……………………………………………………………………………..

IS THERE ANY HISTORY OF FITS/EPILEPSY IN CHILD'S PARENTS/BROTHERS/SISTERS YES/NO

IMMUNISATION/VACCINATIONS (please enter details below, indicating whether the immunization by your GP/Health Clinic or privately.)

IMMUNISATION/VACCINATION	GIVEN BY GP/HEALTH CLINIC	GIVEN PRIVATELY	DATE
BCG			
1st Diphtheria/Pertussis/Tetanus/Polio/Hib			
1st Rotavirus			
1st PCV			
2nd Diphtheria/Pertussis/Tetanus/Polio/Hib			
2nd Rotavirus			
Men C			
3rd Diphtheria/Pertussis/Tetanus/Polio/Hib			
2nd PCV			
1st Measles/Mumps/Rubella (MMR)			
3rd PCV			
Hib/MenC			
Diphtheria/Pertussis/Tetanus/Polio			
2nd Measles/Mumps/Rubella (MMR)			