

CHILDRENS QUESTIONNAIRE

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

First Name:	Surname:
Previous Surname (if any)	Date of Birth:
Place of Birth:	Ethnicity:
Country of Birth:	Contact Telephone Number:

Home Address:

Full Name of Parent(s)	Name of School/Nursery and Address:
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Previous GP Name and Address:	Your Previous Address:
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Do you have your child's Red or Baby book? YES / NO

CHILD MEDICAL HISTORY

Has your child had any of the following?

Measles Yes / No Mumps Yes / No

Chicken Pox Yes / No

German measles Yes / No Whooping Cough Yes / No

Has your child had any Hospital Admissions and what for? _____

Has your child had any serious illness or accidents? _____

Does your child have an allergies or Drug reactions? _____

Does your child take any regular medication for any illness? _____

VACCINATION HISTORY

Please complete the record below and forward this questionnaire back to the surgery. Thank you.

Immunisation	Yes / No	Locations Given: (Name & Address)	Date Given
1 st Dip/Tet/Pert/Hib/Polio (old injection)			
1 st Meningitis C			
1 st DTaP/IPV/Hib (new injection)			
2 nd Dip/Tet/Pert/Hib/Polio (old injection)			
2 nd Meningitis C			
2 nd DTaP/IPV/Hib (new injection)			
3 rd Dip/Tet/Pert/Hib/Polio (old injection)			
3 rd Meningitis C			
3 rd DTaP/IPV/Hib (new injection)			
Meningitis C single			
Prevenar (pneu) (1)			
Prevenar (pneu) (2)			
Prevenar (pneu) (3)			
Menitorix combined (Hib-b & Meningitis C)			
1 st MMR			
2 nd MMR			
Measles single			
Mumps single			
Rubella single			
Pre-School Booster: DTaP/IPV (new injection)			
Booster DT + Polio vac (old injection) Age 14 to 18 years			