Grey Gable Surgery, High Street, Inkberrow, Worcs. WR7 4BW Tel: 01386 793007

CHILDREN'S QUESTIONNAIRE

(Before 16th birthday)

PLEASE COMPLETE AS MANY QUESTIONS AS YOU CAN ABOUT YOUR CHILD.
THIS INFORMATION WILL HELP THE PRACTICE TO PROVIDE BETTER MEDICAL CARE FOR YOUR FAMILY.

Surname:					**Male / female:**		
Forenames:					**Date of Birth:**		
Previous surname:					**Ethnicity:**		
Address: **Post code:**							
Mobile No:					**First Language:**		
Mobile belongs to:	**Parent**	**Child**			**Home Telephone No:**		
Name and address of previous doctor:							
Are you a carer?	**yes**		**no**		**If yes, for whom?**		
Next of Kin					**Relationship**		
If over 14 years old, do you smoke?	**yes**		**no**		**If yes, how many per day?**		

CHILD'S MEDICAL HISTORY (Please tick)

HAS YOUR CHILD EVER HAD … ?	✓		✓
Measles ?		Fits ?	
Mumps ?		Chicken Pox ?	
German Measles ?		Whooping Cough ?	
Asthma ?		Any serious illness or accidents ?	
Is there any history of fits / epilepsy in child's parents / brothers / sisters?			
Any historic hospital admissions? For what?			
Is your child presently undergoing any medical care/follow up at hospital?	Yes?	Name of hospital: Name of consultant: Speciality:	

VACCINATIONS (information can be found in child's 'RED BOOK')

VACCINATION	✓	WHERE (GP SURGERY/CLINIC)	DATE
First DTP/ DT & Polio			
Second DTP / DT & Polio			
Third DTP / DT & Polio			
Measles			
Measles / Mumps / Rubella (MMR)			
Pre-school Booster (DT & Polio)			
Rubella Booster			
BCG			

(DTP = Diphtheria / Tetanus / Pertussis (whooping cough), DT = Diphtheria / Tetanus)