CHILDRENS QUESTIONNAIRE

Children aged under 16

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_______________

Forename:________________________ **Surname**:_________________________

Date of Birth:______________________ Place of Birth:______________________

Birth Weight: ______________________

Address:____

____

Postcode: ________________________ Telephone: __________________

Email Address:___________________________ Mobile:_____________________

Consent to receive communication by text & email ☐ Yes

Previous Address: ____

____

Previous GP:____

Address / Telephone No:____

School: ____

Nursery: ____

Mother's Name: ____

Father's Name:____

Next of Kin (Name):________________ Relationship:______________________

Address:____ Tel:________________

____

Other members of your household – please list everyone who lives with you (adults & children):

Name	Date of Birth / Age	Relationship

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Ethnicity: White / Black / Mixed Race / Asian / Arabic / Indian / Caribbean / African / Chinese / European / British / English / Irish / Scottish / Welsh / Other __________________	
Language: Please state your main first spoken language:______________________________	
Preferred Language:____________________	Religion:______________________________
Country of Birth:_______________________	Date first entered UK:_____/______/______ *(If not born in UK)*

CHILD'S MEDICAL HISTORY

Has your child had:		☐	MEASLES	☐	MUMPS
☐	GERMAN MEASLES	☐	WHOOPING COUGH	☐	ASTHMA
☐	CHICKEN POX	☐	MENINGITIS	☐	FITS
☐	OTHER SERIOUS ILLNESS – Please give details____________________________________				
☐	ANY SERIOUS ACCIDENTS – Please give details____________________________________				

Previous Medication:____

Allergies:____

Is there any family history of Asthma / Fits / Epilepsy in the child's parents / brothers / sisters? ☐ Yes / ☐ No

If Yes, please give details:____

____

IMMUNISATIONS

Please tick if they have been given & by whom. (Please give dates if possible)

Date Due	VACCINATION	Given by:	Date:
8 weeks old	1st triple & polio - Diphtheria, tetanus, pertussis (whooping cough), polio, Haemophilus influenza type b (Hib) and hepatitis B		
	1st Meningococcal group B (MenB)		
	1st Rotavirus gastroenteritis		
12 weeks old	2nd triple & polio - Diphtheria, tetanus, pertussis, polio, Hib, HepB		
	1st Pneumococcal (PCV)		
	2nd Rotavirus		
16 weeks old	3rd triple & polio - Diphtheria, tetanus, pertussis, polio, Hib, HepB		
	2nd Meningococcal group B (MenB)		
One year old	Hib and MenC		
	Pneumococcal (PCV booster)		
	Measles, mumps and rubella (German measles) (MMR)		
	Meningococcal group B (MenB booster)		
3y 4m old	Diphtheria, tetanus, pertussis, polio booster		
	MMR booster		
12 to 13 years	HPV (2 doses 6-24 months apart)		
14 years *(school year 9)*	Tetanus, diphtheria, polio		
	MenACWY		
Any Other:			

Parent / Guardian Signature: ____