**NORTH RIDGE MEDICAL PRACTICE**

**NEW PATIENT QUESTIONNAIRE FOR CHILDREN UNDER 12**

FULL NAME ………………………………………………… DoB:……………….

ADDRESS ……………………………………………………………………………..

…………………………………………………………………………………………..

…………………………………………………………………………………………..

NAME OF MOTHER ……………………………

NAME OF FATHER…………………………….

OCCUPATION OF FATHER…………………………………………………………

OCCUPATION OF MOTHER…………………………………………………………

CONTACT TELEPHONE NUMBERS. DAY-TIME………………………………..

 EVENING………………………………..

IS THERE ANY FAMILY HISTORY OF :-

ASTHMA. YES/NO WHO?…………………………………………………

DIABETES. YES/NO WHO?...........................................................................

CANCER. YES/NO WHO?..........................................................................

STROKE. YES/NO WHO? ……………………………………………….

HEART DISEASE. YES/NO WHO?.................................................................

HAS YOUR CHILD HAD ANY SERIOUS ILLNESS OR OPERATIONS? DATES

………………………………………………………….. ………….

…………………………………………………………. …………..

…………………………………………………………. …………..

DOES YOUR CHILD HAVE ANY CURRENT MEDICAL PROBLEMS?

…………………………………………………………………………………………

IS YOUR CHILD ON ANY MEDICATION?

……………………………………………………………………………………….

DOES YOUR CHILD HAVE ANY KNOWN ALLERGIES?

…………………………………………………………………………………………..

IMMUNISATION DETAILS

DIPTHERIA YES/NO if yes when?..............................................

TETANUS YES/NO if yes when?..............................................

PERTUSSIS YES/NO if yes when?..............................................

[whooping cough]

HIB YES/NO if yes when?..............................................

POLIO YES/NO if yes when?..............................................

MMR YES/NO if yes when?..............................................

RUBELLA YES/NO if yes when?..............................................

PSB YES/NO if yes when?.............................................

 [Pre-school booster]

MEN C YES/NO if yes when?..............................................

PNEUMOCOCCAL YES/NO if yes when?..............................................

ROTAVIRUS YES/NO if yes when?..............................................

ETHNICITY [please tick]

WHITE BRITISH BRITISH/MIXED BRITISH IRISH

OTHER WHITE WHITE & BLACK AFRICAN WHITE & ASIAN

OTHER MIXED INDIAN/BRITISH PAKISTANI/BRITISH

BANGLADESH/BRITISH OTHER ASIAN CARIBBEAN

AFRICAN OTHER BLACK CHINESE

OTHER

Thank you for taking the time to fill out this form, your Doctor will find the information given very helpful in assessing your child’s medical needs. If your child is over the age of 5 years, please bring him/her along for a health check when you come for yours.