Children’s Questionnaire (New Patient)

Name of child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who has parental responsibility for this child? : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If school age, which school does the child attend?: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Immunisations

Is your child up to date with their vaccinations? Yes/No

Dates of: Triple/polio/HIB: ………………………………………………………………………………………………

………………………………………………………………………………………………..

MMR: ………………………………………………………………………………………………………………

Men B: ……………………………………………………………………………………………………………..

Pneumococcal: ………………………………………………………………………………………………..

Rotavirus: …………………………………………………………………………………………………………

Medical History

Does your child suffer from any medical condition/illness? Yes/No

If yes, what?

Communication Issues:

Does the child have any information or communication needs, sight/hearing/learning disability etc.:

Yes (please state): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

No

Does the child have a Social worker? Yes/No

Is the child ‘looked after’?

Give name/names below of any other adults in the home:

Summary Care Records

I confirm that I have read and understand the information given to me and that:

I wish to opt in

I wish to opt out

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Parent/Guardian) Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_