

**NEW PATIENT QUESTIONNAIRE FOR 0 - 5 YEARS**

Please fill in or tick all sections to enable us to care for your child whilst notes are sent for.

Name ..... DoB .....

**Names of Parent(s) /Guardian**

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**Birth Details**

Premature ..... Full Term ..... 40 wks+ .....

**Delivery Details**

Normal .....Forceps ..... Suction ..... Caesarean .....

**Immunisation Details**

Triple Polio Hib\_ 1<sup>st</sup> ..... 2<sup>nd</sup> ..... 3<sup>rd</sup> .....

MMR ..... Pre School Booster .....

Hospital Visits or Admissions – when and what for .....

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General Health – Problems if any .....

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**ETHNICITY**

We are required to collect ethnicity information on all our patients. Please tick one of the following boxes.

White		Mixed Race		Asian	
Caribbean		African		Chinese	
Japanese					

FIRST LANGUAGE: .....

