NEW PATIENT QUESTIONNAIRE FOR 5 - 13 YEARS

Please fill in or tick all sections to provide us with information whilst the notes are being sent for.

Name ……………………………………………….. DoB ……………………

Names of Parent(s) /Guardian

………………………………………………………………………………..

Height ……………………………….. Weight ………………………………

Immunisation Details

Triple Polio Hib 1st ……….. 2nd ………….. 3rd ………….MMR………

Pre school booster ……………...Polio / Tetanus Booster …………..

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

………………………………………………………………………………………

General Health – Problems if any ……………………………………………..

………………………………………………………………………………………..

Regular Medication – if any ……………………………………………………

………………………………………………………………………………………

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………………………………………..

Are you taking any regular medication? YES NO

If ‘Yes’ please enclose repeat prescription slip from your previous doctor’s surgery

Are you allergic to any medications? If 'Yes' please give details:-

Drugs What Reaction

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FAMILY HISTORY

Have you or any close relatives suffered from any of the following?

Problem	You	Family Member/s	Age at onset
Heart Attack/Angina			
High Blood Pressure			
Diabetes			
Epilepsy			
Psychiatric disorder			
Glaucoma			
Thyroid Disease			
Cancer (Breast/Bowel/Lung)			

Signature on behalf of patient……………………………………

Date…………………………………………………………………