WARGRAVE SURGERY

NEW PATIENT QUESTIONNAIRE FOR PARENTS OF A CHILD UNDER 5 YEARS

SURNAME _____	FORENAMES _____
ADDRESS _____	DATE OF BIRTH _____
_____	TELEPHONE _____
_____	PARENT'S MOBILE PHONE NUMBER _____
FIRST LANGUAGE _____	ETHNICITY _____

MOTHER'S SURNAME (if different from child)	FATHER' SURNAME (if different from child)

Welcome to our Practice. As it may be a while before your child's past records are sent to us, please complete the details below so that we know as much about your child as possible. Please add any extra details you think will be helpful.

What injections has your child had, and when?

	Date	Date	Date	Date
Diptheria				
Tetanus				
Whooping Cough				
Polio				
Hib.				
Pneumococcal				
Meningitis C				
MMR				
Pre-School Booster				
BCG				

I agree that my child named above should continue the Immunisation Programme.

Signature of Parent/Guardian. _____ Date: _____

Has your child had any illnesses?

Asthma	Yes/No	Chicken Pox	Yes/No
Eczema	Yes/No	Mumps	Yes/No
Tonsillitis	Yes/No	Measles	Yes/No
Ear Infections	Yes/No	Other (please specify)	_____

Has your child had any operations ?
Is your child allergic to any drugs, dressings or food?
Are there any inherited conditions in your family that your child suffers from or might suffer from?
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