

CHILD (UNDER 10)

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**Tel. Appointments & Queries 01769 580269**

**Patient Questionnaire**

**PERSONAL INFORMATION**

Name : .....

Male or Female: .....

Address: ..... Date of Birth: .....

..... Weight: .....

..... Height: .....

..... Waist measurement.....

Post Code: .....

Tel No: .....

How would you describe your diet as? .....

How much exercise do you take? None / 1x week / 2x week / more often

Form of exercise e.g. Swimming / Walking? .....

Have any members of your family suffered from any of the following:

Condition / Illness	Member of family
Heart Attack < 60	
Heart Attack > 60	
Angina < 60	
Angina > 60	
Stroke	
Diabetes	
Asthma	

Have you got any medical conditions e.g., Diabetes, Asthma, Blood Pressure, Eye Problems.

Please list: 1) .....

2) .....

3) .....

Have you had any operations? Please list.

1) .....

2) .....

3) .....

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Do you have any allergies? YES / NO

(If yes please describe .....

Do you currently have any ongoing blood tests or investigations? YES / NO

(If yes please give details .....

Please give the dates when your child had the following immunisations:

**Diphtheria, Tetanus, Pertussis:**

1<sup>st</sup> ..... 2<sup>nd</sup> ..... 3<sup>rd</sup> .....

**Polio:**

1<sup>st</sup> ..... 2<sup>nd</sup> ..... 3<sup>rd</sup> .....

**Haemophilus Influenza B:**

1<sup>st</sup> ..... 2<sup>nd</sup> ..... 3<sup>rd</sup> .....

**Meningitis C:**

1<sup>st</sup> ..... 2<sup>nd</sup> ..... 3<sup>rd</sup> .....

Single .....

**MMR (Measles, Mumps, Rubella):**

1<sup>st</sup> ..... Booster .....

or Measles .....

Pre School Booster .....

Date: ..... Signature: .....

**If you take any medication please make an appt to see a doctor.**