Date: _____

CHILDREN'S QUESTIONNAIRE

Surname: _____

First Name: _____

Parent's Surname: _____

Date of Birth: _____

Address: _____

_____ Post Code: _____

Telephone Number: _____

School: _____

Previous Address: _____

_____

_____

Name and Address of Previous Doctor:

_____

_____

1. Has your child had any operations, serious illnesses or accidents?

Please enter details

YEAR	CONDITION

2. <u>Drugs And Medicines</u>

Is your child currently taking any regular treatment, if so which ones?

_____

_____

_____

_____

3. Is your child allergic to any tablets or medicines?

If so, which ones: _____

_____

4. Has your child had any of the following illnesses?

Measles **YES** ☐ **NO** ☐

Mumps **YES** ☐ **NO** ☐

Asthma **YES** ☐ **NO** ☐

Whooping Cough **YES** ☐ **NO** ☐

5. Immunisations/Vaccinations

*Please give the exact **<u>DATE</u>** and **<u>WHERE</u>** it was given*

TYPE		DATE	GP/CLINIC
Triple + Polio	1st		
	2nd		
	3rd		
HIB	1st		
	2nd		
	3rd		
MMR			
Pre-School Booster			