chippingnorton
Health Centre

CHILDREN'S HEALTH QUESTIONNAIRE

Date: ………………………….

Please complete as many questions as you can about your child. The information will help the practice to provide better medical care for your family. You will need to bring the following when registering:

Identification (passport, birth certificate) ☐ **Completed Registration Form** (GMS1) ☐ **Childrens Red Book** ☐

Surname ………………………………………………….. Parents' Surname …………………………………………………………

First Name ………………………………………………….. Phone No. …………………………………………………………

Date of Birth ………………………………………………… Place of Birth …………………………………………………………

Nursery, Pre-school, Daycare Provider: ………………………………………………………………………………………………

Address ………………………………………………………….. Parent's Address (if different) ………………………………………

…………………………………………………………………………. ……………………………………………………………………………

Name and Address of Previous Doctor ………………………………………………………………………………………

ETHNIC ORIGIN **Please complete this section and tick as appropriate**

White British	☐	White Irish	☐	White Other	☐
Black African	☐	Black Caribbean	☐	Indian	☐
Bangladeshi	☐	Pakistani	☐	Chinese	☐
Other Ethnic Group	☐	Mixed Race	☐		

Is English your child's first language? If not, please specify: ………………………………………………………

MEDICAL HISTORY

Please list any serious illnesses, accidents or operations (continue overleaf if necessary):
Date: Details:

Is your child allergic to anything? YES/ NO If yes, please specify:

Is your child taking any drugs or medicines? YES/NO If yes, please specify (continue overleaf if necessary):
Medicine/Tablets Dose or strength How many times a day

Is there any history of bed wetting/asthma/eye problems in children under 8 or other health problems in your *immediate* family?

Has your child had a hearing test? YES/NO

Your child's current weight: and height:

Are there any aspects of your child's health you are concerned about? (Continue overleaf if necessary):