COUNTIES MEDICAL FAMILY HEALTH

New Patient Medical Questionnaire Up to 16 years of age

Please complete one form for <u>each member</u> of your family and hand back to reception

Name: _____

DOB: __/__/____

Medications:

Is your child currently taking Medication?	No ☐	Yes ☐ (please list)
Is your child taking any non-prescribed medicines or supplements eg St John's Wort?	No ☐	Yes ☐ (please list)
Is your child allergic to any medications?	No ☐	Yes ☐ (please list)

Medical History:

Does your child have any long-term medical conditions or disability? (E.g., asthma, diabetes, prem baby, heart disease)	No ☐	Yes ☐ (please list)
Has your child been in hospital for any procedure, illness or under the care of a specialist?	No ☐	Yes ☐ (please list)

Lifestyle:

(Children aged 15 years & over please answer this section)

Are you a current smoker of tobacco?	No ☐	Yes: ☐ Number per day ____ and number of years a smoker _____ Would you like help to quit smoking Yes / No
Have you ever smoked tobacco?	No ☐	Yes: ☐ Number per day ____ and number of years a smoker _____ Year ceased smoking _____

Immunisations:

Is your **child immunisations** up to date? ☐ Yes ☐ No ☐ Don't know ☐ Declined Immunisations

(if given Overseas, a copy of the immunisation records is required)

Signed:_____ Date:_____

Parent / Guardian

If you enrolled and requested your medical notes to be transferred from your previous GP we wish to advise you that we will hold these securely for reference only. The notes will not be specifically reviewed unless you request us to, or unless the Doctor feels that your medical history warrants this. ***Please be careful to disclose all important medical/surgical/psychiatric information.***