SWALLOWFIELD MEDICAL PRACTICE
NEW PATIENT QUESTIONNAIRE FOR PARENTS OF A CHILD UNDER 14 YEARS

SURNAME _____	FORENAMES _____
ADDRESS _____	DATE OF BIRTH _____
_____	TELEPHONE _____
_____	PARENT'S MOBILE PHONE No _____ ☐
	Please Tick if you **DO NOT** want to receive text reminders
MOTHER'S SURNAME (if different from child)	FATHER'S 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
Diphtheria				
Tetanus				
Whooping Cough				
Polio				
Hib				
Men B				
Pneumococcal				
Meningitis C				
MMR				
Rotavirus				
Pre-School Booster				
BCG				

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

Signature of Parent/Guardian .....

Has your child had any illnesses?

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

Has your child had any operations?
Is your child taking any medications?
EPS – (electronic prescribing system) for non-dispensing patients only. What is your nominated chemist?
Is your child allergic to any drugs, dressings or food?