

HONITON GROUP PRACTICE CHILD QUESTIONNAIRE

DATE:

Surname:	Forenames:
Address:	Telephone No:
Postcode:	
Name and address of last GP:	
<p>MEDICAL HISTORY Past Illnesses (including hospital admissions, operations etc):</p>	
Is there a history of asthma, eczema or hay fever? YES / NO	
Birth history (any problems of pregnancy, delivery, first few weeks of life)	
<p>Medicines (Please list any medicines or tablets currently taken)</p>	
On prescription:	
Not on prescription:	

Medicines (cont.)	
Any allergies to medicine or tablets? YES / NO	
If yes, please give details:	
<i>Name of medicine</i>	<i>Type of Reaction</i>
<p>IMMUNISATIONS:</p> <p>To the best of your knowledge, please indicate which of the following immunisations your child has received and give dates where possible:</p>	
<i>1st DPT/Polio & Hib</i>	<i>YES / NO</i>
<i>2nd DPT/Polio & Hib</i>	<i>YES / NO</i>
<i>3rd DPT/Polio & Hib</i>	<i>YES / NO</i>
<i>MMR 1 / 2</i>	<i>YES / NO</i>
<i>DT & Polio (Booster)</i>	<i>YES / NO</i>
<i>Meningitis C</i>	<i>YES / NO</i>
<p>Family History:</p>	
Father	Age
Mother	Significant Illnesses
Brother/s	
Sister/s	