BIRDHURST MEDICAL PRACTICE

1 Birdhurst Avenue, South Croydon, Surrey CR2 7DX
Tel: 020-8686-2070 Fax: 020-8686-0824

UNDER 16'S QUESTIONNAIRE

SURNAME:……**FIRST NAMES:**……..

Mother's surname (if different)……..

Father's surname (if different)**.....**

DATE OF BIRTH: / / SEX: M/F TEL NOS: Home……

Mobile…….

ADDRESS …….

……. **POSTCODE:**……..

EMERGENCY CONTACT ……. **TEL NO.** ……..……..

RELATIONSHIP TO CHILD ……..

CARERS NAME ……. **TEL NO.** ……
(If applicable)

ARE YOU A CARER? Do you look after a friend or relative? Yes / No

SCHOOL/NURSERY ……..

ETHNIC ORIGIN: White British ( ) White Irish ( ) White Other ( ) Black British ( )
Mixed White & Black Caribbean ( ) Mixed White & Black African ( )
Mixed White & Asian ( ) Mixed Other ( ) Indian - Asian or British Asian ( )
Pakistani - Asian or British Asian ( ) Bangladeshi - Asian or British Asian ( )
Asian or British Asian - Other ( ) Caribbean - Black or Black British( )
African - Black or Black British ( ) Other - Black or Black British( )
Chinese - Other ( ) Any Other Ethnic Group ( ) Sri Lankan ( )

FIRST LANGUAGE SPOKEN: …….....

Please tick if you would like to opt out of Summary Care Records ( ) ask reception if you require more information

Please tick if you would like to opt out of sharing your patient non identifiable data ( )

PTO

MEDICAL INFORMATION:

DATE	PREVIOUS MEDICAL PROBLEMS / OPERATIONS

DATE	CURRENT PROBLEMS	MEDICATION & DOSAGE

Has anyone in your immediate family (mother, father, brothers or sisters) had any of the following:-

High Blood Pressure	No ( )	If yes - Who?……..Age when diagnosed……..
Angina or heart attack	No ( )	If yes - Who?……..Age when diagnosed……..
Stroke	No ( )	If yes - Who?……..Age when diagnosed……..
High level of cholesterol	No ( )	If yes - Who?……..Age when diagnosed……..
Diabetes	No ( )	If yes - Who?……..Age when diagnosed……..
Asthma	No ( )	If yes - Who?……..Age when diagnosed……..
Thyroid problems	No ( )	If yes - Who?……..Age when diagnosed……..
Breast cancer	No ( )	If yes - Who?……..Age when diagnosed……..
Bowel Cancer	No ( )	If yes - Who?……..Age when diagnosed……..
Cancer – other	No ( )	If yes - Who?……..Age……Type…….

Do you have any allergies? Please List: ……..

Do you have any Information or Communication needs relating to disability, impairment or sensory loss?
If yes, then please describe/list: **……..**

IMMUNISATIONS
Please give us information regarding the following immunisations, if you have had them.

IMMUNISATION	FIRST DATE	SECOND DATE	THIRD DATE	GP SURGERY YES/NO
Diphtheria/Tetanus/Whooping Cough/Hib				
Polio				
Meningitis C				
Hepatitis B				
Measles/Mumps/Rubella				
Hib (if given after the age 1 year)		N/A	N/A	
Pre-school booster (Dip/Tet/Polio/Whooping Cough)		N/A	N/A	

Any other vaccinations, including travel, please list below including date given: