



Patient Questionnaire (Child)

Welcome to the practice. Please help us by filling in as much of this questionnaire as possible.

Surname :

Forenames :

Address :

Postcode :

Tel No:

Parent or patients mobile number:

Email address:

Next of kin name & contact number:

Date & Place of birth :

Previous Address :

Previous postcode:

Ethnic Origin (please chose from codes below) :

Your NHS Number :

First language:

Admin only: NHS CARD YES NO

Identification Documents YES NO

Previous GP :

Address :

Are the following vaccinations up to date?

Diphtheria/Tetanus/Whooping Cough (Triple) Hib

YES NO

Polio

YES NO

Measles/Mumps/Rubella (MMR) – N.B 2 doses required

YES NO

BCG (Tuberculosis)

YES NO

Meningitis

YES NO

Other (specify)

YES NO

Please give dates from Red Book

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Are you currently under the care of a Hospital Consultant?

Is there any significant family history we should be aware of?

Do you suffer from asthma?

Do you take any medicines or treatment? (please state dosage)

Please list any known allergies

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Ethnic data codes**White:**

British	01
Irish	02
Other mixed	03

Mixed:

White & black Caribbean	04
White & black African	05
White & Asian	06
Other mixed	07

Asian or Asian British:

Indian	08
Pakistani	09
Bangladeshi	10
Other Asian	11

Black or Black British:

Black Caribbean	12
Black African	13
Other Black	14

Other Ethnic:

Chinese	15
Other Ethnic category	16

Not stated	17
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