

# CHILDREN'S MEDICAL HISTORY QUESTIONNAIRE (5 to 6yrs)

Date  /  /

Please complete this form as FULLY AS POSSIBLE to provide the Doctors with information about your child, whilst we await your child's records from your previous Doctor.  
If non applicable please mark as "NONE" in appropriate box.

## About your child

Surname:  Male/Female:   
Forename:  Date of Birth:  /  /

Does your child attend school? No  Yes

If yes please name school

## Past Medical History

please list any serious medical illness, hospital treatment or operation your child has ever had, including the year that the illness happened.

Year	Illness

Please list any TABLETS, DRUGS or INHALERS that your child is using:

## Allergies

Please list any allergies your child may have:

Who is the child's Main carer? e.g. Parent, Guardian, Foster Parent etc.

Surname:

Forename:

Telephone Numbers:

Are you an Asylum Seeker? No  Yes

Are you a Refugee? No  Yes



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