Davidsons Mains Medical Centre

LIFESTYLE QUESTIONNAIRE – CHILD (under 12)

Confidential

Date:

Full Name:	**Date of Birth:**
Address:	**Male / Female:**
	Telephone:
Postcode:	**Previous GP:**
Previous GP Address:	
Guardian:	**Guardian Address:**
Guardian Telephone:	
Which Ethnic Grouping describes you best? Please circle one of the following:	
White/Black Carribean/Black African/Black other/Indian/Pakistani/Bangladeshi/Chinese/Other Ethnic	

Previous Health

Child's Place of Birth:	**Birth Weight:**
Has your child ever had any serious illness or hospital admissions?	
Give year and illness:	

Relevent History

Do any diseases run in your family such as heart disease, high blood pressure, diabetes or asthma?

Has your child had a full course of immunisations against:

2 mths – DTaP/IPV/Hib, PCV (pneumococcal conjugate vaccine) Protecting against – Diphtheria, Tetanus and Pertussis (whooping cough), Polio and Haemophilus influenzae type b (Hib), Pneumococcal infection	**Yes / No**
3 mths – DtaP/IPV/Hib, Men C Protecting against – Diphtheria, Tetanus and Pertussis (whooping cough), Polio and Haemophilus influenzae type b (Hib), Meningococcal C (MenC)	**Yes / No**
4 mths - DtaP/IPV/Hib, Men C, PCV (pneumococcal conjugate vaccine) Protecting against - Diphtheria, Tetanus and Pertussis (whooping cough), Polio and Haemophilus influenzae type b (Hib), Meningococcal C (MenC), Pneumococcal infection	**Yes / No**
12–13 mths (within a month of 1st birthday) – Hib/Men C, MMR, PCV Protecting against - Haemophilus influenzae type b (Hib), Meningococcal C (Men C), Measles Mumps & Rubella (German Measles), Pneumococcal Infection (PCV)	**Yes / No**
3yrs 4mth to 5yrs – Dtap/IPV or dTap/IPV, MMR Protecting against - Diphtheria, Tetanus, Pertussis and Polio, Measles, Mumps & Rubella	**Yes / No**
12-18 yrs – Td/IPV, HPV (3 inj over a period of 6 mths for girls (12-13 yrs old) Protecting against – Tetanus, diphtheria and polio. Cervical cancer caused by Human Papilloma Virus (HPV)	**Yes / No**

Medication:

Medication at present (including bought medicines):
Does your child have any allergies to medicines:

Other Information

Which school does he/she attend?	
Does he have any special educational needs?	
Is he or she disabled, blind or deaf?	

For Completion by GP or Nurse

Date of check:	**/ /**			
Height:	**Weight:**	**BP:**	**Urine gluc:**	**Prot:**
Action:				
Coding: (For data entry and initial/date when done) -				

Updated 25/7/2024 - S:\Office Documents\Registrations