DATE: ……..

WEST HAMPSTEAD MEDICAL CENTRE
9 SOLENT ROAD
LONDON NW6 1TP

Child Health Questionnaire

SURNAME: ..... FIRST NAME(S): ……

DATE OF BIRTH: …….....

Reason for joining our practice: ☐ Moved to area ☐ Prefer New GP ☐ Other……

MAIN CARER: …… RELATIONSHIP TO CHILD:……...
(Name)

PHONE: ……

PERSONAL HISTORY

1. Has your child ever suffered from any of the following?
(If yes, please give details)

Heart Problems ☐ **YES** ☐ **NO** ……..
Stroke ☐ **YES** ☐ **NO** ……..
Diabetes ☐ **YES** ☐ **NO** ……..
Asthma ☐ **YES** ☐ **NO** ……..
Cancer ☐ **YES** ☐ **NO** ……..

Have they had any other illnesses or operations/surgery? ☐ **YES** ☐ **NO**
(If yes, please give details) …….....
……

2. Is your child currently on any medications? ☐ **YES** ☐ **NO**
(If yes, please list names & dosages) …….
……

3. Do they have any known allergies? ☐ **YES** ☐ **NO**
(If yes, please give details) ……

4. Does your child have any special needs/care requirements? ☐ **YES** ☐ **NO**
(If yes, please give details)…….
……

5. How would you best describe your child's ethnic background? (This is not necessarily the same as nationality or country of birth)**.**

☐ **White British** ☐ **White & Asian** ☐ **Chinese** ☐ **Other Asian ……..**
☐ **Irish** ☐ **Indian** ☐ **Carribean** ☐ **Other Black …….....**
☐ **Pakistani/Brit** ☐ **Bangladeshi/Brit** ☐ **African** ☐ **Other Mixed …….....**
☐ **Other White …….....** ☐ **Other** (details) **…….....**

6. What is your child's main spoken language?

☐ **English** ☐ **French** ☐ **Italian** ☐ **Spanish** ☐ **Arabic**
☐ **Greek** ☐ **Bengali** ☐ **Punjabi** ☐ **Somali** ☐ **Mandarin**
☐ **Gujarati** ☐ **Albanian** ☐ **Urdu** ☐ **Turkish** ☐ **Japanese**
☐ **Other** (please state) …….

Do you/your child need an interpreter? ☐ **YES** ☐ **NO**

7. Does your child have to follow a special diet? ☐ **YES** ☐ **NO**

Weight-Reducing	☐ **YES**	☐ **NO**	**Low Fat or Cholesterol**	☐ **YES**	☐ **NO**
Vegetarian	☐ **YES**	☐ **NO**	**Low Salt**	☐ **YES**	☐ **NO**
High Fibre	☐ **YES**	☐ **NO**	**Gluten-Free**	☐ **YES**	☐ **NO**
Milk/Dairy-Free	☐ **YES**	☐ **NO**	**Other** (details) ……..		

8. Is your child physically active? (Please give details of type/duration of exercise)

Exercise is physically impossible ☐ **……..**
Exercise less than once/week ☐ **…….....**
Exercise 1 to 3 times/week ☐ **……**
Exercise more than 3 times/week ☐ **……**

9. Does your child attend Nursery or School? ☐ **YES** ☐ **NO**
(If yes, please give name and location of school)……...
……

10. Has your child had any immunisations? ☐ **YES** ☐ **NO**
(If yes, please give names of vaccines/dates/where given, if known or provide copy of records ('red book')

☐ 1st DTap/Hib/Polio ……	☐ 1st Meningitis C ……	☐ Pneumococcal ……	☐ Other ……... ……...
☐ 2nd DTap/Hib/Polio ……	☐ 2nd Meningitis C ……	☐ Pneumococcal ……	☐ Other…… ……...
☐ 3rd DTap/Hib/Polio ……	☐ 3rd Meningitis C ……	☐ Pneumococcal ……	☐ Other…… ……...
☐ 1st MMR ……	☐ Booster DTP/Polio ……	☐ MMR booster ……..	☐ Other ……... ……...
☐ BCG ……			

FAMILY HEALTH HISTORY

11. Has any family member (including parents, siblings, aunts, uncles, grandparents) **ever suffered from any of the following?** (if yes, please give details, whom affected etc)

Heart Problems ☐ **YES** ☐ **NO** **……..**
Stroke ☐ **YES** ☐ **NO** **……..**
Diabetes ☐ **YES** ☐ **NO** **……..**
Asthma ☐ **YES** ☐ **NO** **……..**
Cancer ☐ **YES** ☐ **NO** **……..**
Other ☐ **YES** ☐ **NO** **……..**