The Grove Medical Centre
CHILDRENS QUESTIONNAIRE.

Date.....

Surname..... Phone No ……..

First Name..... School .....

Date of Birth..... M/F…….. Previous GP ……

Address..... Previous Address.....

....

Post Code..... Post Code.....

Mothers Name…….. DOB…… NHS No……...

Fathers Name …….. DOB …….. NHS No ……..

Ethnic Origin…….. First Language……

CHILDS MEDICAL HISTORY.

Has your child had:

Measles	Yes/No	Mumps	Yes/No
German Measles	Yes/No	Asthma	Yes/No
Whooping Cough	Yes/No	Fits	Yes/No
Chicken Pox	Yes/No	Any serious illness	
Any Hospital Admissions	Yes/No	or accidents	Yes/No

Is there any history of Fits/Epilepsy in child's parents/brothers/sisters? Yes/No

VACCINATIONS. (Please tick if they have been done and by whom)

	GP / CLINIC	DATE
First DTP/DT + Polio + HIB + Pneu		/
Second DTP/DT + Polio + HIB + MenC		/
Third DTP/DT + Polio + HIB + Menc + Pneu		/
Measles/Mumps/Rubella (MMR)		/
Pre-School Booster (DT + Polio) +MMR		/
HIB/Men C Booster		/