Health Questionnaire for Children

Personal Details Date Completed _____ Nationality _____

Title: _____ Full Name: _____

Date of Birth: _____ Any previous names? _____

Address: _____

_____Post code: _____

Telephone _____ Mobile _____

If not British origin - how long have you been in this country? _____

Next of Kin:
(please list all who can be contacted with regard to the child's health)

1st Name: _____ Relationship to child:_____

Address (if different to child's): _____

_____ Email: _____

Contact Numbers: (Home): _____(Mobile): _____

2nd Name: _____ Relationship to child:_____

Address (if different to child's): _____

_____ Email: _____

Contact Numbers: (Home): _____(Mobile): _____

3rd Name: _____ Relationship to child:_____

Address (if different to child's): _____

_____ Email: _____

Contact Numbers: (Home): _____(Mobile): _____

4th Name: _____ Relationship to child:_____

Address (if different to child's): _____

_____ Email: _____

Contact Numbers: (Home): _____(Mobile): _____

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BIRTH

Were there any complications with your child's birth? YES / NO

If yes, please give details: _____

CHILDHOOD ILLNESSES

Please tick if your child has had any of these, and approximate age if possible:

Mumps	☐	Age _____	Measles	☐	Age _____
Chickenpox	☐	Age _____	German Measles	☐	Age _____
Scarlet Fever	☐	Age _____	Rheumatic Fever	☐	Age _____
Whooping Cough	☐	Age _____	Childhood Eczema	☐	Age _____
Childhood Asthma	☐	Age _____	Diphtheria	☐	Age _____

ALLERGIES

Is your child allergic or sensitive to any medications, food, animals etc.?

ILLNESSES, ACCIDENTS OR OPERATIONS

Please list all serious illnesses, accidents, hospital admissions or operations with dates and hospital attended:

CURRENT MEDICATIONS AND WHAT THEY ARE PRESCRIBED FOR:

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BLOOD

Do you know your child's blood group YES / NO

If yes, please state it: _____

Has your child ever received a blood transfusion? YES / NO

If yes, please give details: _____

WEIGHT

What is your child's weight? _____

HEIGHT

What is your child's height? _____

FAMILY HISTORY

Does the child, parents or any close relations have any of the following? (please give details)

Diabetes	YES / NO	_____
High blood pressure	YES / NO	_____
Heart Attack	YES / NO	_____
Stroke	YES / NO	_____
Epilepsy or fits	YES / NO	_____
Asthma	YES / NO	_____
Skin Disease	YES / NO	_____
Anxiety / Depression	YES / NO	_____
Cancer	YES / NO	_____
Kidney Disease	YES / NO	_____
Other	YES / NO	_____