

HEALTH QUESTIONNAIRE (Children under the age of 16)

Please bring your immunisation book with you.

NAME: _____
ADDRESS: _____
 _____ Post Code _____
Date of Birth: _____ **Tel No:** _____
Approx. Height: _____ **Approx. Weight:** _____
Today's Date _____

Current Medication (Please take any medication with you):

¹Allergic reaction to medication / previous vaccine

(Please give details ie Type of Reaction): _____

Previous Medical History:

<p>^aSerious Illnesses:</p> <p>_____</p> <p>_____</p>
<p>^bOperations :</p> <p>_____</p>

<p>^cCurrently attending Out Patient Department: (Please give details) _____</p> <p>_____</p>
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ACTION
(Surgery use only)

On Computer

Sticker ¹

On Computer

Refer to Asthma ^{2a}
Clinic

Refer to Dr ^{2a}

Refer to Dr ^{2b}

Advise to inform
OPD of change ^{2c}
of address & Dr

GPC over 5 years

TO BE COMPLETED FOR ALL CHILDREN AGED 7 YEARS OR YOUNGER

To generate the follow up of immunisations, we require details of immunisations already carried out

Immunisation	Date of 1st	Date of 2nd	Date of 3 rd	Booster
Diphtheria, Tetanus, Pertussis (Whooping cough) Polio+HIB +HepB				
Pneumococcal				
Meningitis B				
Rotavirus				
Diphtheria, Tetanus, Pertussis and Polio				
MMR (Measles, Mumps, Rubella)				
HIB/MenC				

If **NOT** had Pertussis immunisation please tick box

Immunisations added
to computer