

Ivel Medical Centre – Patient Information
CHILDREN AGED 5 AND UNDER

Name.....

Address.....

Date of Birth.....Telephone Number.....

Next of Kin..... Telephone Number

Relationship.....

What is your main language spoken?

FAMILY HISTORY (Including parents and grandparents)
 Have any members of your family suffered from the following?

Diabetes	Yes/No	Asthma	Yes/No	Heart Problems	Yes/No
Stroke	Yes/No	High Blood Pressure	Yes/No	Cancer	Yes/No

GENERAL HISTORY

Have you had any serious illnesses or operations?

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Do you have any allergies?

Are you on any medication? YES/NO If yes please list.

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Vaccination history. It is easier for us and provides more accurate information if you could bring your child's/children's Red Book for your first visit here.

Please fill in the following up-to-date information. It is probably easier to copy it from your child's Red Book. If you do not have a Red Book with you at present, would you please fill in, as nearly as you can remember, the **date and place** of your child's vaccinations.

	8 weeks Date:	12 weeks Date:	16 weeks Date:	13 months Date:	4 year booster Date:
DTP (Triple)				xxxxxxxxxx	
Polio				xxxxxxxxxx	
Hib				xxxxxxxxxx	xxxxxxxxxxxxxxxx
MMR (Measles, Mumps, Rubella)	xxxxxxxx	xxxxxxxx	xxxxxxxx		
Meningitis C					xxxxxxxxxxxxxxxx
Hib/Men C Booster					
Pneumococcal					