

Chawton House Surgery
St Thomas Street, Lymington HANTS SO41 9ND
TEL: 01590 672953 FAX: 01590 674137

MEDICAL HISTORY OF CHILDREN UNDER 16 YEARS

Dear Parent

As we may not receive your child's medical records for several months, it would be very helpful if you could tell us a little about him/her in the following confidential questionnaire. Please hand the completed questionnaire in at reception. Thank you for your co-operation.

SURNAME _____

FORENAMES _____

DATE OF BIRTH _____

ETHNIC GROUP WHITE · BLACK AFRICAN · BLACK CARIBBEAN · INDIAN · PAKISTANI · CHINESE ·
Please Circle
DECLINE TO STATE · OTHER - PLEASE STATE

ADDRESS _____

POSTCODE _____ TELEPHONE NO. _____

NAME OF PARENT/GUARDIAN _____

HOME TEL NO _____ EMERGENCY CONTACT NO. _____

PREVIOUS DOCTOR _____
SURGERY ADDRESS _____

Has your child had:

Any major illnesses or hospital admissions?

Date

Diagnosis

1. _____

2. _____

3. _____

Does your child have:

Any allergies? (Please specify)

Have any close relatives ever suffered from: (i.e. parents, brothers, sisters only)

	YES	NO	RELATIONSHIP
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

If your child is taking any regular medication or they have any health issues then please make a routine appointment to see the Doctor