

Strathcairn Medical Practice

St Andrews Community Hospital
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CHILD PATIENT QUESTIONNAIRE

This questionnaire is to help us get to know your child.

1) Contact information

Child's name (First) _____ (Last) _____

Date of birth _____ Sex M F Ethnic origin _____

Parent's / Guardian's names

(First) _____ (Last) _____

(First) _____ (Last) _____

Address _____

_____ Postcode _____

Tel: Home _____ Work _____ Mob _____

2) Vaccination history

VACCINATION

DATE GIVEN

1st Diphtheria, Whooping cough, Tetanus, Polio, Hib and Pneumococcal _____

2nd Diphtheria, Whooping Cough, Tetanus, Polio, Hib and Men C _____

3rd Diphtheria, Whooping Cough, Tetanus, Polio, Hib, Pneumococcal and Men C _____

Hib and Men C booster _____

Mumps, Measles and Rubella (MMR) and Pneumococcal _____

Booster Diphtheria, Whooping cough, Tetanus and Polio (pre-school booster) & MMR _____

OTHER VACCINATIONS

DATE GIVEN

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

3) Do any of the family (parents of child, brothers or sisters) suffer from:

Asthma Yes No If yes please state family member _____

Diabetes Yes No If yes please state family member _____

Epilepsy Yes No If yes please state family member _____

4) Has the child ever had any serious illnesses, injuries or operations? Yes No

Date _____ Description _____

Date _____ Description _____

5) Does the child have any allergies Yes No

If yes, type of allergy _____

6) Any other comments