# Children's Questionnaire

Name: _____ Surname: _____

Are You? (Please tick) Male: ☐ Female: ☐ DOB: _____

Address: _____

_____ Email: _____

Tel: _____ Mobile: _____

Parent / Carer: _____

Parent / Carer Contact Number: _____

Do you take regular medication? Please Explain

_____

_____

Any serious illnesses, operations or admissions? Please Explain

_____

_____

Are you allergic to anything? Please Tick and Explain

Yes: ☐ No: ☐ _____

_____

First Spoken Language: _____

Name of School / Nursery: _____

<u>Summary Care Record</u>: Would you like to have a summary care record? (shared record with healthcare staff) Yes ☐ No ☐ (Sign opt out form)

<u>Patient Online Access</u>: Accessing GP services at home, work or on the move 24 hours a day. Includes appointment booking, requesting repeat medication, secure messaging and viewing of medical records. Please speak to a receptionist to register.

| Immunisations Given | | Y / N | Date | Place given |
|---|---|---|---|---|
| DTAP/IPV/HIB | 2 months | | | |
| Prevenar | | | | |
| Meningitis B | | | | |
| Rotavirus | | | | |
| DTAP/IPV/HIB | 3 months | | | |
| Rotavirus | | | | |
| DTAP/IPV/HIB | 4 months | | | |
| Meningitis B | | | | |
| Prevenar | | | | |
| HIB/MenC | 12 months | | | |
| Prevenar | | | | |
| MMR | | | | |
| Meningitis B | | | | |
| MMR Booster | 3 months after 1st MMR | | | |
| DTaP/IPV | 3 years and 4 months | | | |

Ethnicity Group (Please tick the appropriate box) 

**White**

British ☐ Irish ☐ Any Other White ☐ Prefer Not To Say ☐

**Black**

African ☐ Caribbean ☐ Any Other Black ☐

**Asian**

Indian ☐ Pakistani ☐ Bangladeshi ☐ Any Other Asian ☐

**Mixed**

White & Black Caribbean ☐ White & Black African ☐

White & Asian ☐ Any Other Mixed ☐

**Other Ethnic Groups**

Chinese ☐ Any Other Ethnic Group ☐

**Accessible Information Standard**

**(for patients with a disability, impairment or sensory loss)**

My information and communication preferences are:

 Easy Read ☐  Large Print ☐  BSL ☐

 Email ☐  Text ☐  Other ☐ _____