**North Croydon Medical centre**

**Dr. Thawda Win** MBBS

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**CONFIDENTIAL**

**CHILDREN HEALTH QUESTIONNAIRE**

**TO BE COMPLETED BY THE PARENT OR GUARDIAN OF CHILDREN UNDER THE AGE OF 16**

Please complete as many questions as you can. If you cannot answer any particular question, just go the next one

|  |  |
| --- | --- |
| Surname: | First Name: |
| Gender: Female ☐ Male ☐ | D.O.B: |
| Address:  Post Code: | Home Tel:  Mobile :  School Tel: |

|  |  |
| --- | --- |
| Child’s Place of Birth: | If born overseas when did your child move to UK (month and year): |

|  |  |
| --- | --- |
| Parent or guardian’s details:  Parent ☐ Guardian ☐ | Surname:  First Name: |
| Address: | Home Tel:  Mobile Tel: |

Please provide your child’s ethnicity details (We have been asked by the NHS to collect ethnicity data to help them monitor the health of different ethnic group in Croydon). Please tick an appropriate box.

|  |  |  |  |
| --- | --- | --- | --- |
| **code no** | **WHITE** | **code no** |  |
| 9S10 | White British ☐ | 9S8 | Bangladesh ☐ |
| 9S11 | White Irish ☐ | 9SH | Other Asian ethnic group ☐ |
| 9S12 | Other white ethnic group ☐ |  | OTHER ETHNIC GROUPS |
|  | **BLACK OR BLACK BRITISH** | 9S9 | Chinese ☐ |
| 9S2 | Black Caribbean ☐ | 9SJ | Other ethnic group ☐ |
| 9S3 | Black African ☐ |  | **MIXED** |
| 9SG | Other black ethnic group ☐ | 9SB5 | White and Black Caribbean ☐ |
|  | **ASIAN OR ASIAN BRITISH** | 9SB6 | White and Black African ☐ |
| 9S6 | Indian ☐ | 9SB4 | Other ethnic, Asian/white origin ☐ |
| 9S7 | Pakistani ☐ | 9SD | Other ethnic, other mixed origin ☐ |

I do not wish to disclose my child’s ethnicity details ☐

**CHILD’S MEDICAL HISTORY**

|  |  |  |
| --- | --- | --- |
| Does your child suffer from any of the conditions listed below:  Asthma ☐ Diabetes ☐ High Blood Pressure ☐ Cancer ☐ Yellow Jaundice ☐ Heart trouble ☐ Glaucoma ☐ Tuberculosis ☐ | Please detail any other serious or chronic illnesses, operations or disabilities: | |
| Is your child allergic to anything? | | |
| Is your child currently taking any drugs or medicines?  Yes ☐ No ☐ | | If yes please list all treatments/ medicines etc. |

**VACCINATIONS**

|  |  |  |  |
| --- | --- | --- | --- |
| DTaP/Hib and Pneumococcal (PCV) | At 2 months old | Yes ☐  No ☐  Don’t Know☐ | Date: |
| DTaP/IPV/Hib and MenC | At 3 months old | Yes ☐  No ☐  Don’t Know☐ | Date: |
| DTaP/IPV/HIB/MenC and PCV | At 4 months old | Yes ☐  No ☐  Don’t Know☐ | Date: |
| Hib/MenC | Around 12 months | Yes ☐  No ☐  Don’t Know☐ | Date: |
| MMR and PCV | Around 13 months | Yes ☐  No ☐  Don’t Know☐ | Date: |
| DTaP/IPV or DTaP/IPV and MMR | 3 years 4 months to 5 years old | Yes ☐  No ☐  Don’t Know☐ | Date: |
| Td/IPV | 13 to 18 years old | Yes ☐  No ☐  Don’t Know☐ | Date: |

|  |  |
| --- | --- |
| As far as you are aware does your child smoke? | Yes ☐ No ☐  Never smoked tobacco☐ Pipe smoker ☐  Stopped smoking Cigar smoker ☐  Date ……………………. Roll own cigarettes ☐  Less than Thinking about giving ☐  1 cigarettes/day ☐ Trying to give up ☐  1/9 cigarettes/day ☐ Thinking about giving up☐  20-39 cigarettes/day ☐  40+ cigarettes/day ☐ |
| Would you like any advice on how she/he could stop smoking? | Yes ☐ No ☐ |

|  |  |
| --- | --- |
| As far as you are aware does your child drink alcohl? | Yes ☐ No ☐  If yes what is average weekly consumption;  Pints of beer/lager/cider ……………………  Glasses of wine/ port …………………………  Measures of spirit ……………………………… |

|  |  |
| --- | --- |
| Is your child a carer for someone? | **Yes No**  **If yes (who for?) ……………………………** |

**All Family members who live in the same household (Please list all members of family)**

|  |  |  |
| --- | --- | --- |
| **Full Name** | **Relation to child** | **Address** |
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**Date form completed: ………………………………………..**

**Parent/ Guardian signature: ……………………………….**