COURTYARD SURGERY
New Patient Registration Health Questionnaire (Child 15 & Under)

Name:……………………………….…….. **Date** …………………………………...

D.O.B:……..………………………………. **Sex: (M/F)** ……..………………………

Address: ………………………………………………………………………………

Name of Parent or Guardian: ………………………………………..……………...

School Attended: …………………………………………...………………………

What is your childs: **Height** ……….…… **Weight** ……..…….

Immunisations **Date given or declined**

Two months old	Diptheria/Tetanus/Pertussis	Dose 1	
	Polio	Dose 1	
	Hib	Dose 1	
	Pneumococcal	Dose 1	
Three months old	Diptheria/Tetanus/Pertussis	Dose 2	
	Polio	Dose 2	
	Hib	Dose 2	
	Meningitis	Dose 1	
Four months old	Diptheria/Tetanus/Pertussis	Dose 3	
	Polio	Dose 3	
	Hib	Dose 3	
	Meningitis	Dose 2	
	Pneumococcal	Dose 2	
Around 12 months	Hib/Men C		
Around 13 months	MMR1 (Measles/mumps/rubella)		
	Pneumococcal booster		
Three years and four months or soon after	Diphtheria/Tetanus/ Pertussis (pre school)		
	Polio pre school		
	MMR 2		

Others (please give details): ………………………………………………………………

Does your child have any allergies: (please specify) ……………………….……………

……………………………………………………………………..……….…..….…….……..

Does your child take regular medication prescribed by your doctor or purchased over the counter.

Please list:

Name of Medication	Dose

Please bring a urine sample with you to the surgery.

30/10/2014/JY