

Medical History – Children 15 & Under

CLINICAL INFORMATION - Page 1 of 2 *(Please give this sheet to the Doctor or Nurse)*

As a new patient, completing this form helps us get a detailed overview of your child’s health. This form is confidential and will only be kept in their individual confidential medical record.

NameDate of birth.....

If possible, please bring to the consultation:

- Records of childhood (and travel) vaccinations
- Child Health Record (for pre-school children or if otherwise relevant)
- Asthma Management Plan, if relevant

Please tick routine immunisations received

Birth 2 months 4 months 6 months 12 months 18 months Four year old

Your child’s current or past health or developmental problems *(please mark)*

Any major problems during pregnancy or soon after birth?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Spina bifida	Yes <input type="checkbox"/> No <input type="checkbox"/>
Skin problems: eczema/seborrheic dermatitis/other	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cerebral palsy	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diabetes	Yes <input type="checkbox"/> No <input type="checkbox"/>	Autism/Asperger’s	Yes <input type="checkbox"/> No <input type="checkbox"/>
Vision or eye problems	Yes <input type="checkbox"/> No <input type="checkbox"/>	ADHD or behavioural disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>
Deafness or concern about hearing	Yes <input type="checkbox"/> No <input type="checkbox"/>	Anxiety/depression/obsessive-compulsive disorder/ other mental health problem	Yes <input type="checkbox"/> No <input type="checkbox"/>
Recurrent ear infections	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Asthma/other lung problems..... If asthma: Does your child have a current Asthma Management Plan?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Teeth/gum problems..... Does your child see a dentist regularly?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Coeliac disease/lactose intolerance/other malabsorption	Yes <input type="checkbox"/> No <input type="checkbox"/>	Concerns about bed-wetting? Other toileting concerns?	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Seizures/epilepsy	Yes <input type="checkbox"/> No <input type="checkbox"/>	Constipation	Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney problems/ recurrent urinary infections	Yes <input type="checkbox"/> No <input type="checkbox"/>	Concerns about speech and language development?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cancer/ leukaemia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Learning difficulties	Yes <input type="checkbox"/> No <input type="checkbox"/>
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Concerns about other aspects of development?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Unusual or severe infection/ meningitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Concerns about obesity?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Migraine or severe headache	Yes <input type="checkbox"/> No <input type="checkbox"/>	Operations/surgery (please list)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Head injury	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Continued over

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Name:.....

Have any other **family** members had any of the following?

Childhood or early adulthood cancer (incl skin cancer) Type(s):	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hereditary conditions or those detected at birth or that run in the family:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anxiety/depression/suicide	Yes <input type="checkbox"/> No <input type="checkbox"/>	Asthma/eczema/hay fever Some clinical problems are more (or less) likely	Yes <input type="checkbox"/> No <input type="checkbox"/>
Other serious childhood illness you are concerned about (any detail):	Yes <input type="checkbox"/> No <input type="checkbox"/>	to occur in people of particular ethnic backgrounds. If you wish us to be aware of your child's ETHNIC ORIGINS, please record here:	

SCHOOL attended.....

MEDICATION LIST including over-the-counter remedies

Name	Strength	Doses	Reason

ALLERGIES TO MEDICATION:

OTHER SIGNIFICANT ALLERGIES (e.g. to nuts, eggs):

CARE ARRANGEMENTS and confidentiality

PLEASE ADVISE who the child primarily lives with (mum / dad / both parents / stepmother / stepfather / foster parent etc.):

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And the name and relationship of any other parent/ carer that the child lives with or is involved with:

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