WESTONGROVE PARTNERSHIP

CONFIDENTIAL

ASTON CLINTON SURGERY
BEDGROVE SURGERY
WENDOVER HEALTH CENTRE

HEALTH DATA FORM FOR CHILDREN AGED 6 TO 14 YRS

*Please use a ballpoint pen and **PRINT** clearly*

Child's surname

Forenames *(underline name by which usually known)*

Mother's full name

Father's full name

Address

Postcode

Telephone no:

Date of birth

☐ DAY ☐ MONTH ☐ YEAR

Place of birth

Ethnicity

This information can help us plan to meet the needs of the community and ensure that everyone has equal access to the health care we provide. The classification is entirely voluntary but will help us to provide a better service.

- A White British ☐
- B White Irish ☐
- C Any other White background ☐
- D White and Black Caribbean ☐
- E White and Black African ☐
- F White and Asian ☐
- G Any other mixed background ☐
- H Indian ☐
- J Pakistani ☐
- K Bangladeshi ☐
- L Any other Asian background ☐
- M Caribbean ☐
- N African ☐
- P Any other Black background ☐
- R Chinese ☐
- S Any other ethnic group ☐

Please list below any *major* illnesses, accidents, or operations. Do not include colds, sore throats, 'flu, etc. unless they recur persistently.

Age of Child At Onset	Condition/Operation	Hospital (if applicable)

Is your child sensitive to anything such as penicillin, aspirin, plaster, etc.

Allergy	What Does It Do?

Is your child taking or using any regular medication at present?

Type	Dosage

Please list any immunisations:

		DATE	PLACE (SURGERY OR CLINIC)
Triple* & Polio 1	☐	....	....
Triple* & Polio 2	☐	....	....
Triple* & Polio 3	☐	....	....

**Triple=diptheria, tetanus and whooping cough*

Was whooping cough vaccine included above? ☐ YES ☐ NO

		DATE	PLACE (SURGERY OR CLINIC)
Pre-school booster	☐	....	....
HIB 1	☐	....	....
HIB 2	☐	....	....
HIB 3	☐	....	....
MMR	☐	....	....
BCG	☐	....	....
MMR 2	☐	....	....
MEN C	☐	....	....

Has anyone in the child's family suffered from these conditions?

Condition		Relationship to Child
Asthma	☐	....
Eczema	☐	....
Hay Fever	☐	....
Bronchitis	☐	....
Fits	☐	....
Mental Depression	☐	....
Other Psychiatric Problems	☐	....
Diabetes	☐	....
High Blood Pressure	☐	....
Angina/Heart Attack	☐	....
High Cholesterol	☐	....
Glaucoma	☐	....

Has anyone in your child's family ever had cancer?

Relationship To You	Type of Cancer	Age At Onset

Is your child now under hospital treatment or on the waiting list for any surgical procedure?

☐ YES ☐ NO

**Please give details:*

Has your child any major handicap, disability, social problem, or other matter you would like your doctor to know about?