

ASTON CLINTON SURGERY
 BEDGROVE SURGERY
 WENDOVER HEALTH CENTRE

HEALTH DATA FORM FOR CHILDREN UP TO 5 YRS

Please use a ballpoint pen and PRINT clearly

Please list any immunisations:

	DATE	PLACE (SURGERY OR CLINIC)
Triple* & Polio 1	<input type="checkbox"/>
Triple* & Polio 2	<input type="checkbox"/>
Triple* & Polio 3	<input type="checkbox"/>

**Triple=diphtheria, tetanus and whooping cough*

Was whooping cough vaccine included above? YES NO

Pre-school booster	<input type="checkbox"/>
HIB 1	<input type="checkbox"/>
HIB 2	<input type="checkbox"/>
HIB 3	<input type="checkbox"/>
MMR	<input type="checkbox"/>
BCG	<input type="checkbox"/>
MMR 2	<input type="checkbox"/>
MEN C	<input type="checkbox"/>

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?

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

	Relationship to Child
Asthma	<input type="checkbox"/>
Eczema	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>
Bronchitis	<input type="checkbox"/>
Fits	<input type="checkbox"/>
Mental Depression	<input type="checkbox"/>
Other Psychiatric Problems	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>
Angina/Heart Attack	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>

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

Relationship To You	Type of Cancer	Age At Onset

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	<input type="checkbox"/>	J Pakistani	<input type="checkbox"/>
B White Irish	<input type="checkbox"/>	K Bangladeshi	<input type="checkbox"/>
C Any other White background	<input type="checkbox"/>	L Any other Asian background	<input type="checkbox"/>
D White and Black Caribbean	<input type="checkbox"/>	M Caribbean	<input type="checkbox"/>
E White and Black African	<input type="checkbox"/>	N African	<input type="checkbox"/>
F White and Asian	<input type="checkbox"/>	P Any other Black background	<input type="checkbox"/>
G Any other mixed background	<input type="checkbox"/>	R Chinese	<input type="checkbox"/>
H Indian	<input type="checkbox"/>	S Any other ethnic group	<input type="checkbox"/>

The baby's birth. Were there any problems?

Premature Forceps/Ventouse Delivery

Caesarean Section Admission to SCBU

Other.....

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