



LAKESIDE HEALTHCARE

at Oundle

CHILD QUESTIONNAIRE (For aged 15 and under)

IF you are aged 16 and over please fill in the Adult questionnaire

SURNAME:**FORENAME (S):****D.O.B:**

ADDRESS:**POSTCODE:**

HOME TEL:**MOBILE TEL:** We do NOT use SMS messaging for under 16 year olds

PARENTAL RESPONSIBILITY Please name any adults living with the child and state their relationship to the child, including any carers.

Is this child a 'looked after' child? Yes No
 By 'looked after, we mean under the care of a guardian or anyone else other than the parent(s).

Does this child currently or ever had a Social Worker involved with their care?
 YES NO

Date (to/from) social worker involved: _____ to _____
 Social worker details including contact telephone number:

PREVIOUS NURSERY/SCHOOL:

CURRENT or NEW NURSERY/SCHOOL:

DOES THIS CHILD HAVE ANY CURRENT MEDICAL CONDITIONS or DISABILITIES?

CURRENT HEIGHT: **CURRENT WEIGHT:**
 Please use most recent values in your child's red book

DOES THIS CHILD HAVE ANY ALLERGIES? No Yes Please state:

IS THIS CHILD UNDER HOSPITAL CARE AT THE MOMENT? IF SO PLEASE STATE:

HOSPITAL:

CONSULTANT NAME:

CONSULTANT SPECIALITY:



IF THIS CHILD HAS REPEAT MEDICATION, PLEASE PROVIDE US WITH A COPY OF THEIR REPEAT PRESCRIPTION LIST

SIBLINGS Please give names of any siblings. If you are registering all siblings at the same time, this information is not required.

FOR ALL CHILDREN AGED 14 AND OVER
Do you smoke? Yes No If yes, how many? ____ per day / week / month (delete as appropriate)
Prefer not to answer

IF YOU ARE REGISTERING FROM OVERSEAS, PLEASE PROVIDE A COPY OF ALL VACCINATIONS ADMINISTERED.

Ethnicity: (Please note that you do not have to complete this section)

White British <input type="checkbox"/>	British or mixed British <input type="checkbox"/>	Other White background <input type="checkbox"/>
Asian Indian <input type="checkbox"/>	Asian Pakistani <input type="checkbox"/>	Asian Bangladeshi <input type="checkbox"/>
Black Caribbean <input type="checkbox"/>	Black African <input type="checkbox"/>	Chinese <input type="checkbox"/>
Mixed White & Asian <input type="checkbox"/>	Mixed White & Black Caribbean <input type="checkbox"/>	Mixed White & Black African <input type="checkbox"/>
Other (Please state): _____		Prefer not to answer <input type="checkbox"/>

First language: _____ **Is an interpreter required?** _____

Thank you for taking the time to complete this questionnaire

For Office Use Only _____

Patient Verification

Documentation Seen: _____

Seen by: _____ Date: _____

Added to SystemOne By: _____ Date: _____