Patient Questionnaire: Child

Please complete a separate questionnaire for each of your children. If you are unsure about any of the questions, please leave the answer blank.

Personal Details

Surname:

Forenames:

Date of Birth: Sex: ☐ Male ☐ Female

Address:

Postcode:

We need to know your child's First Language – Please tell us which language is mainly spoken in your home:

Ethnic Origin (please tick one)
Asian or Asian British – Bangladeshi
Asian or Asian British – Indian
Asian or Asian British – Other Background
Asian or Asian British – Pakistani
African
Caribbean
Other Black
Mixed Race – Other Background
Mixed Race – White and Asian
Mixed Race – White and Black African
Mixed Race – White and Black Caribbean
Other – Any Other
Other – Chinese
White – British
White – Irish
White – Other Background

Height: **Weight:** (If Known)

Parent/Guardian Contact Details

Mother/Guardians	Father/Guardians
Name:	Name:
Address:	Address:
Telephone Home:	Telephone Home:
Mobile:	Mobile:
Email:	Email:

Medical Details

Personal Medical History:

Year Details

Known Allergies:

Teenagers Only: - Do you smoke? ☐ Current Smoker ☐ Never Smoked

How many a day?