BROOM ROAD MEDICAL PRACTICE
CHILDREN HEALTH QUESTIONNAIRE (CHILDREN UNDER THE AGE OF 16)

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CONFIDENTIAL
CHILDREN HEALTH QUESTIONNAIRE

TO BE COMPLETED BY THE PARENT OR GUARDIAN OF CHILDREN UNDER THE AGE OF 16

Please complete as many questions as you can. If you cannot answer any particular question, just go the next one

Surname:	First Name:
Gender: Female ☐ Male ☐	D.O.B:
Address: Post Code:	Home Tel: Mobile : School Tel:

Child's Place of Birth:	If born overseas when did your child move to UK (month and year):

Parent or guardian's details: Parent ☐ Guardian ☐	Surname: First Name:
Address:	Home Tel: Mobile Tel:

Please provide your child's ethnicity details (We have been asked by the NHS to collect ethnicity data to help them monitor the health of different ethnic group in Croydon). Please tick an appropriate box.

code no	**WHITE**	**code no**	
9S10	White British ☐	9S8	Bangladesh ☐
9S11	White Irish ☐	9SH	Other Asian ethnic group ☐
9S12	Other white ethnic group ☐		OTHER ETHNIC GROUPS
	BLACK OR BLACK BRITISH	9S9	Chinese ☐
9S2	Black Caribbean ☐	9SJ	Other ethnic group ☐
9S3	Black African ☐		**MIXED**
9SG	Other black ethnic group ☐	9SB5	White and Black Caribbean ☐
	ASIAN OR ASIAN BRITISH	9SB6	White and Black African ☐
9S6	Indian ☐	9SB4	Other ethnic, Asian/white origin ☐
9S7	Pakistani ☐	9SD	Other ethnic, other mixed origin ☐

I do not wish to disclose my child's ethnicity details ☐

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CHILD'S MEDICAL HISTORY

Does your child suffer from any of the conditions listed below: Asthma ☐ Diabetes ☐ High Blood Pressure ☐ Cancer ☐ Yellow Jaundice ☐ Heart trouble ☐ Glaucoma ☐ Tuberculosis ☐	Please detail any other serious or chronic illnesses, operations or disabilities: __________ __________ __________
Is your child allergic to anything?	
Is your child currently taking any drugs or medicines? Yes ☐ No ☐	If yes please list all treatments/ medicines etc.

VACCINATIONS

DTaP/Hib and Pneumococcal (PCV)	At 2 months old	Yes ☐ No ☐ Don't Know☐	Date:
DTaP/IPV/Hib and MenC	At 3 months old	Yes ☐ No ☐ Don't Know☐	Date:
DTaP/IPV/HIB/MenC and PCV	At 4 months old	Yes ☐ No ☐ Don't Know☐	Date:
Hib/MenC	Around 12 months	Yes ☐ No ☐ Don't Know☐	Date:
MMR and PCV	Around 13 months	Yes ☐ No ☐ Don't Know☐	Date:
DTaP/IPV or DTaP/IPV and MMR	3 years 4 months to 5 years old	Yes ☐ No ☐ Don't Know☐	Date:
Td/IPV	13 to 18 years old	Yes ☐ No ☐ Don't Know☐	Date:

As far as you are aware does your child smoke?	Yes ☐ No ☐ Never smoked tobacco☐ Pipe smoker ☐ Stopped smoking Cigar smoker ☐ Date …………………… Roll own cigarettes ☐ Less than Thinking about giving ☐ 1 cigarettes/day ☐ Trying to give up ☐ 1/9 cigarettes/day ☐ Thinking about giving up☐ 20-39 cigarettes/day ☐ 40+ cigarettes/day ☐
Would you like any advice on how she/he could stop smoking?	Yes ☐ No ☐

As far as you are aware does your child drink alcohl?	Yes ☐ No ☐ If yes what is average weekly consumption; Pints of beer/lager/cider …………………… Glasses of wine/ port ………………………… Measures of spirit ………………………………

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Is your child a carer for someone?	**Yes** ☐ **No** ☐ **If yes (who for?)** …………………………..

<u>All Family members who live in the same household (Please list all members of family)</u>

Full Name	Relation to child	Address

Date form completed: ………………………………………..

Parent/ Guardian signature: ………………………………..