**West London Medical Centre– Health Questionnaire for Children (0- 15yrs)**

Surname………………………………………………………….. Sex : Male/Female

Forenames....................................................................................... DOB:…………..

Address…………………………………………………………….

………………………………………………… Post code…………………

Name of main carer(s) ……………………… …….Relationship……………………………

Status of parents -Married / Separated/ Divorced/Common law partners/Foster /……………

First language of parents……………………………………………

Languages spoken by child (if applicable) …………………………

Name of school……………………………………………………

State any problems at birth or in the first few weeks of life

……………………………………………………………………….

Developmental problems ………………………………………

……………………………………………………………………….

Illnesses/Operations ………………………………………………

……………………………………………………………………….

Regular medications………………………………………

……………………………………………………………………….

Allergies……………………………………………………………...

**Family History (any serious illness in close relative)**

Mother…..………………………………………..

Father………………………………………….....

Brother(s)………………………………………..

Sister(s) ………………………………………….

**Immunisation Records** -Please provide **accurate** details of all immunisations

 Vaccine Date given Place given

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 8weeks (2months) |

|  |
| --- |
| Dip/Tet/Pert/Polio/Hib and hepatitis B  |

Meningitis BRotavirus |  |  |
| Twelve weeks(3months) |

|  |
| --- |
| Dip/Tet/Pert/Polio/Hib and hepatitis B  |

Pneumococcal vaccineRotavirus |  |  |
| Sixteen weeks (4 months) |

|  |
| --- |
| Dip/Tet/Pert/Polio/Hib and hepatitis B  |

RotavirusMeningitis B |  |  |
| One year old | Hib and Men CPneumococcal vaccineMMR (Measles, mumps and rubella)Booster Men B |  |  |
| Three years four months (pre -school) | Dip/Tet/Pert/PolioMMR (Pre-school booster) |  |  |
| Twelve to thirteen years | HPV (human papillomavirus) |  |  |
| Fourteen years | Tetanus, diphtheria and polioMeningitis A ,C,W and Y |  |  |
| BCG |  |  |  |

Dip- Diphtheria, Tet- Tetanus, Pert- Pertusis, Hib- Haemophilus influenza, Polio-Poliomyelitis

MMR-Measles, Mumps, Rubella , Men C – Meningitis Group C

**I confirm that all the information given is accurate to the best of my belief .**

Signature of the Parent(s)/Guardian……………………… Date……………..