***Brecon Medical Group Practice***

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| Dr. M.B. Heneghan |  | Dr. C.D. Davies |
| Dr. P.W Metcalfe | TY HENRY VAUGHAN, | Dr. R.S. Matharu |
| Dr. G.M.J. Keely | BRIDGE STREET, | Dr. A.E. Morgan |
| Dr. J.E. Lloyd | BRECON, | Dr. E.R. Lloyd |
| Dr J.J. King | POWYS, LD3 8AH |  |

Tel: (01874) 622121 Fax: (01874) 623742

[www.breconmedicalgroup.co.uk](http://www.breconmedicalgroup.co.uk/)

**UNDER 16s QUESTIONNAIRE**

To be completed in conjunction with Form GMS1W (Family Doctor Services Registration)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Personal Details of Child** | | | | | | |
| **Surname:** | **Forename(S):** | | | | | |
| **Address:**  **Postcode:** | | | | | | |
| **Telephone Contact Details:** | | | **Landline:**  **Mobile:** | | | |
| **Date of Birth:** | | | **Male/Female:** | | | |
| **Ethnicity** (Please circle appropriate option): | | | **White / Black / Nepalese / Asian**  **Chinese / Eastern European**  **South American / Mixed Race / Other** | | | |
| **First Language if applicable:** | | | | |  | |
| **Name of School attended if applicable:** | | | | |  | |
| **Details of Next of Kin** | | | | | | |
| **Relationship to Child:** | | |  | | | |
| **Address:** | | |  | | | |
| **Telephone Contact Details:** | | |  | | | |
| **Details of Person with Parental Responsibility** (named on birth certificate or awarded by Court of Law) | | | | | | |
| **Name of person with Parental Responsibility:** | | |  | | | |
| **Relationship to Child** | | |  | | | |
| **Details of Main Carer** | | | | | | |
| **Full Name of Main Carer:** |  | | | | | |
| **Relationship to Child:** |  | | | | | |
| **Telephone Details of Main Carer:** | **Landline:**  **Mobile:** | | | | | |
| **First Language of Carer:** |  | | | | | |
| **Medical History of Child** | | | | | | |
| **Birth Weight:** | | |  | | | |
| **Problems at birth** (please specify) | | |  | | | |
| **Please provide details of any developmental problems:** | | |  | | | |
| **Please list any illnesses or operations** | | |  | | | |
| **Please indicate any allergies:** | | |  | | | |
| **Please list any current Medications: (Or supply a copy of the current medication list)** | | |  | | | |
| **Please indicate any allergies to medication:** | | |  | | | |
| **Medical Problems of Child** (Please tick if applicable) | | | | | | |
| Asthma | **Yes/No** | | | | Diabetes | **Yes/No** |
| Thyroid Disease | **Yes/No** | | | | Heart Disease | **Yes/No** |
| Epilepsy | **Yes/No** | | | | Other | **Yes/No** |
| **Please provide details of other problems:** | | | | | | |
| **Family Medical History**  Are any of the closest family members affected by (please circle) | | | | | | |
| Asthma | | Diabetes | | | | |
| Glaucoma | | Heart Disease | | | | |
| Blindness | | Tuberculosis | | | | |
| Cancer – Please indicate type if known): | | | | | | |
| Infectious Diseases (Please specify): | | | | | | |
| Other (Please specify): | | | | | | |
| **IMMUNISATION HISTORY** | | **DATE GIVEN** | | | | |
| **1st DTP/Polio** | |  | | | | |
| **2nd DTP/Polio** | |  | | | | |
| **3rd DTP/Polio** | |  | | | | |
| **1st Hib** | |  | | | | |
| **2nd Hib** | |  | | | | |
| **3rd Hib** | |  | | | | |
| **1st Men C** | |  | | | | |
| **2nd Men C** | |  | | | | |
| **Pre School Booster** | |  | | | | |
| **MMR** | |  | | | | |
| **Hib** | |  | | | | |
| **Other** (Please specify) | |  | | | | |
| **ANY OTHER RELEVANT INFORMATION** | | | | | | |
| **Please add any information that you think the Doctor should be aware of:** | | | | | | |
| **Thank you for your time in completing this questionnaire.** | | | | | | |
|  | | | | | | |
| **ADMINISTRATION USE ONLY** | | | | **DATE** | | |
| Form Scanned: | | | |  | | |
| Task sent to GP to review form and ask whether appointment required to be seen: | | | |  | | |