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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:	