THE IVERS PRACTICE

Child Medical Health Questionnaire

Personal details (please circle where appropriate)

Title: Miss/ Ms/ Master/ Other	**Male** **Female** **Other…………………………………………..**
Surname:	**First Name:**
Preferred Name:	
Address:	
	Postcode:
Date of Birth: / /	**School:**
Email Address:	
Name of Parents:	**Preferred Tel No:**
Who do these details belong to? (e.g. mum, dad, child etc.)	
Can we leave messages regarding your child on these numbers?	

Ethnicity:

White – English/Welsh/Scottish/Northern Irish/British/Irish/Gypsy or Irish Traveller/Any other white background

Mixed - White & Black Caribbean /White & Black African /White & Asian /Any other mixed background

Asian or Asian British - Indian/Pakistani/Bangladeshi/Chinese/Any other Asian Background

Black, African, Caribbean or Black British – African/Caribbean/Any other Black, African or Caribbean background

- Place of Birth ____________________________ Religion _________________________________
- What is your first language _________________________ Do you need an interpreter Y / N

Medication:

Is your child on any regular medication?	**Yes** **No**
If Yes, please state Name and dose:	
Is your child allergic to any medication?	**Yes** **No**
If Yes, please state type and name:	

Medication **(Please list all the medications you are taking)**

Name of Medication	Dose	What are you taking it for?

Please continue on a separate sheet if necessary.

Personal Medical History:
Has your child had/still have any of the following: (please circle)

Conditions			**Date**
High Blood Pressure	**Yes** **No**	(Please add approximate date of diagnosis if known)	
Heart Attack or Angina	**Yes** **No**	(Please add approximate date of diagnosis if known)	
High Cholesterol	**Yes** **No**	(Please add approximate date of diagnosis if known)	
Stroke	**Yes** **No**	(Please add approximate date of diagnosis if known)	
Diabetes	**Yes** **No**	(Please add approximate date of diagnosis if known)	
Asthma	**Yes** **No**	If Asthmatic, have they used their inhaler in the past 12 months?	
Depression	**Yes** **No**	(Please add approximate date of diagnosis if known)	
Cancer	**Yes** **No**	(Please add approximate date of diagnosis if known)	
Please give details of any other illnesses, accidents, hospital admissions, investigations or operations your child has had:			

Family History:
Has a first degree relative of your child (parent or sibling) suffered from any of the following conditions?

Conditions		Who?	At what age?
High Blood Pressure	**Yes No**		
Heart Attack or Angina	**Yes No**		
High Cholesterol	**Yes No**		
Stroke	**Yes No**		
Diabetes	**Yes No**		
Asthma	**Yes No**		
Depression	**Yes No**		
Cancer	**Yes No**		

Are you allergic to anything? (Specific medicines or foods i.e. penicillin or aspirin)
____

What is your weight? ______________________ What is your height? ___________________________

Vaccinations:

If your child is 0-7 Yrs please kindly provide us with the information about your child's immunisations that they have received. You MUST bring along any records you have in your RED Child Health Book (vaccination history/book) when you come to the Practice.

Age Due	Vaccine	Tick if Given	Date Given	At GP Surgery	Other
Birth Onwards	BCG, Hepatitis B				
2 Months	1st 6-in-1 Vaccine, 1st Rotavirus, 1st Men B				
3 Months	2nd 6-in-1 Vaccine, 1st Pneumococcal, 2nd Rotavirus				
4 Months	3rd 6-in-1 Vaccine, 2nd Men B				
12 Months	Hib & Men C, 2nd Pneumococcal, 1st MMR, 3rd Men B				
3yrs 4 Months	4-in-1 pre-school booster, 2nd MMR				
12 – 13 Yrs	HPV				
14 Yrs	Tetanus, Diphtheria and Polio, Men ACWY				

Immunisation Records are very important for the wellbeing of your child. Collecting this information will ensure that we have an up to date record, including when the next vaccinations are due.

Smoking Do you smoke? Y / N

a) How many do you smoke per day? ______________________________________
What kind? (Cigars, cigarettes etc.) _______________________________________

b) Tick the statement below that best describes your intentions to stop smoking:

Not interested in stopping ☐
Thinking about stopping ☐
Ready to stop ☐
Trying to give up now ☐
Have made repeated attempted attempts to give up ☐

c) Have you ever smoked? Y/N

When did you stop smoking? ____________________________________

Alcohol – How much alcohol do you drink per week? (On average)

- Pub measures of spirits ____
- Glasses of wine ____
- Pints of beer ____

Exercise – which sentence describes you? (Please tick)

I visit a gym more than once a week ☐
I visit a gym twice a month ☐
I regularly walk (to work, at weekends, around town etc) ☐
I don't enjoy exercise ☐
I find exercise very difficult ☐

Carers

Are you a carer? Y / N

Does someone look after you? Y/N

Further information about support for carers is available at reception – please ask.

Is there anything else we should know:

____

____

____

____

____

Signature : ____

Date : _______________

SHARING MEDICAL RECORDS

SHARE – IN means you allow your GP to access information shared by other health organisations who use the same system and provide you with care. For example a district nurse or a clinician in a community diabetic clinic. If you consent to SHARE - IN, your GP can see that information.

I DO / DO NOT * consent to SHARE – IN my health records.

Signed ………………………………………………………………… Date ………………………………………………………

SHARE – OUT allows your full GP record to be shared and seen by clinicians who are involved in your care and for them to see your shared information with your permission.

I DO / DO NOT * consent to SHARE – OUT my health records.

Signed ………………………………………………………………… Date …………………………………………………………

You can choose to SHARE-IN and SHARE-OUT, do one but not the other or consent to neither.

***** Please delete as appropriate

Alcohol Consumption – AUDIT C

QUESTIONS						Your Score
Scoring System	0	1	2	3	4	
How often do you have a drink containing alcohol ?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+	
How often have you had 6 or more units if female of 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

Score _____________

Scoring:

A total of 5+ indicates increasing or higher risk drinking.
An overall total score of 5 or above is AUDIT-C positive