

CHILD (UNDER 10)

Stratton Medical Centre, Hospital Road, Stratton, Bude, Cornwall

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Patient Questionnaire

PERSONAL INFORMATION

Name:.....

Male or Female:.....

Address:.....

Date of Birth:.....

.....

Weight:.....

.....

Height:.....

.....

Waist Measurement:.....

Post Code:.....

Nationality

Tel No:.....

How would you describe your diet?.....

How much exercise do you take? None / 1x week / 2x week / more often

Form of exercise e.g. Swimming / Walking?.....

Have any members of your family suffered from any of the following:

Condition / Illness	Member of family
Heart Attack < 60	
Heart Attack > 60	
Angina < 60	
Angina > 60	
Stroke	
Diabetes	
Asthma	

Have you got any medical conditions e.g., Diabetes, Asthma, Blood Pressure, Eye Problems?

Please list 1).....

2)

3)

Have you had any operations? Please list.

1)

2)

3)

Please continue overleaf

Child (UNDER 10)

Do you have any allergies? YES / NO
(If yes please describe.....)

Please give the dates when your child had the following immunisations:

Diphtheria, Tetanus, Pertussis:

1st 2nd 3rd

Polio:

1st 2nd 3rd

Haemophilus Influenza B:

1st 2nd 3rd

Meningitis C:

1st 2nd 3rd

Single:

MMR (Measles, Mumps, Rubella):

1st Booster:.....

Or Measles.....

Pre-School Booster.....

Date:..... Signature:.....

If you take any medication please make an appointment to see a doctor.