Staff Initials: ____

ACTON TOWN MEDICAL CENTRE

CHILD HEALTH CHECK QUESTIONNAIRE
(16 and under)

CHILD's NAME: ____

DATE OF BIRTH: ____________________ **ETHNIC ORIGIN**: _____________________

MOBILE NO: _______________________ **HOME PHONE NO**: ___________________

E-MAIL: _______________________________

PREFERRED CONTACT METHOD: SMS , Letter, Email (***Please circle ONE ONLY)***

Do you give consent to receive all SMS messages? **YES / NO** (***Please circle*** **)**
(i.e. appointment confirmations/reminders, etc**)**

English Speaker: Yes / No
If you need an Interpreter, what is your main language? ______________________

Mother's Name: ____

Address if different to the child: ____

Father's Name: ____

Address if different to the child: ____

Name of Primary Carer and any significant other persons: ______________________

Name of person (s) with parental responsibility: ______________________________

Present SCHOOL/ Previous Schools (if applicable): ___________________________

PERSONAL HISTORY

1. Please provide us with your child's immunisation records

2. Is your child on any special diet? ***PLEASE SPECIFY*** _________________

3. Does your child have any allergies? ***PLEASE SPECIFY*** ________________

4. Has your child had any major illnesses/operations? ***PLEASE SPECIFY WITH DATES*** ____

5. Is your child on any repeat medication? ***PLEASE SPECIFY DRUGS AND QUANTITIES***

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FAMILY HISTORY

Do any members of your family suffer from any of the following? ***PLEASE SPECIFY FAMILY MEMBER(S)***

Asthma: ___________________________ Diabetes: ____________________________________

Hypertension: _____________________ Coronary Heart Disease: ______________________

Stroke: ____________________________ Cancer (please specify type): __________________

Mental Illness: ____________________

☐ Signature on behalf of patient Date: ____/____/______

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