COURTFIELD
PRIVATE PRACTICE

NEW PATIENT MEDICAL QUESTIONNAIRE - Under 15 Years

DATE ……

FULL NAME ……

DATE OF BIRTH ……

1. Current Medical Problems:

2. Past Medical History

(*Please list any operations or illnesses you have had – including dates*)

3. Family History

Has there been any serious illness in your family?
(We are particularly interested in: heart disease/stroke, high blood pressure & diabetes)

4. Current Medications

5. Allergies

(*Please list all allergies*)

6. Vaccinations

Name	Dates given
……	……
……	……
……	……
……	……

7. Height ……

Weight ……

CONSENT

By signing below I consent to my health records being accessed and updated by all clinicians at Courtfield Private Practice. I understand Courtfield Private Practice may share information about me and my care with other health professionals.

*(Please note: We will **only** use or pass on identifiable information about you with other health professionals who are involved in the direct provision of your care*).

SIGNATURE …… (*Parent to sign for children under 15 years of age*)

DATE ……