COURTFIELD
PRIVATE PRACTICE

Children New Patient Medical Questionnaire

DATE ……

FULL NAME ……

DATE OF BIRTH ……..……..

1. Current Medical Problems

Past Medical History
(Please list any operations
or illnesses you have had – including dates)

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

2. Current Medications

3. Allergies
(Please list all allergies)

4. Vaccinations

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

5. Height …… Weight ……..

CONSENT

By signing below I consent to my child health records being accessed and updated by all clinicians at Courtfield Private Practice. I understand Courtfield Private Practice may share information about my child and their 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 child's care).

SIGNATURE ……..

(Parent to sign for children under 16 years of age)

DATE ……..