

STRAND MEDICAL GROUP "NEW PATIENT" QUESTIONNAIRE
UNDER 5 YEARS OF AGE

CHILD'S SURNAME: _____ FIRST NAME: _____

NAME OF PARENT / GUARDIAN: _____

WHO HAS PARENTAL RESPONSIBILITY? _____

MOBILE NUMBER: _____ HOME NUMBER: _____

ADDRESS: _____

POST CODE: _____

Ethnicity - Please tick ✓

- | | | |
|---|--|---|
| <input type="checkbox"/> White British | <input type="checkbox"/> British Indian | <input type="checkbox"/> Ethnic category not stated |
| <input type="checkbox"/> Mixed British | <input type="checkbox"/> Bangladeshi | <input type="checkbox"/> Black African |
| <input type="checkbox"/> Irish | <input type="checkbox"/> British Bangladeshi | <input type="checkbox"/> Other black background |
| <input type="checkbox"/> Other white background | <input type="checkbox"/> Black British | <input type="checkbox"/> Chinese |
| <input type="checkbox"/> Indian | <input type="checkbox"/> Black Caribbean | <input type="checkbox"/> Other Asian background |
| | | <input type="checkbox"/> Other mixed background |

Immunisation up to date? YES: NO:

Serious illness in the past: YES: NO:

Please tick ✓ and add date of diagnosis

Asthma _____ Epilepsy _____ Other _____

Diabetes _____ Kidney problems _____ Other _____

Prescribed medicines being taken? YES: NO:

If yes, please specify: _____

Medicine allergy? YES: NO:

If yes, please specify: _____

Other allergy? YES: NO:

If yes, please specify: _____

Height: _____ Weight: _____