Child Health Questionnaire Under 12 years

October 2018 V1

This form is to help us get to know more about your child. Your privacy is important to us. This information will only be seen by your GP and health care team. After the information has been entered into your digital health record, this piece of paper will be destroyed. Please answer as much as possible. If you need help to fill out this form, please ask the Nurse or Receptionist.

PERSONAL DETAILS

Family Name _____ Gender ☐ Male ☐ Female

First Name (s) _____ Date of Birth ☐☐ ☐☐ ☐☐

Preferred Name _____

*UNDER 2 ONLY (*Please circle)

Full term | Born less than 36 weeks

Normal Delivery | C-Section Complication? Yes | No

✓ Gestational Diabetes during pregnancy ☐ Yes ☐ No

PAST MEDICAL HISTORY: √ Has this child ever had any of the following?

☐ Asthma ☐ Eczema ☐ Measles

☐ Whooping cough ☐ Chicken pox ☐ Mumps

☐ Rheumatic Fever ☐ Mental Illness ☐ Others_____

SPECIALIST

Has this child been in hospital? When _____ What for? _____

Has this child been seen by a specialist? Yes / No What for? _____

IMMUNISATION

Immunisations completed ☐ 6 weeks ☐ 3 months ☐ 5 months

☐ 15 months ☐ 4 years ☐ 11 years

Previous influenza injection ☐ No ☐ Yes (Year_____)

ORAL HEALTH

Brush teeth twice a day ☐ Yes ☐ No

Diet – e.g. lollipops and coke ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely

Enrolled with Auckland Regional Dental Service ☐ Yes ☐ No ☐ Unknown

(Please circle one – under 2 only) Bottle | Breastfed

Pacifier Yes | No

DISABILITIES AND IMPAIRMENTS

✓ Does this child have a disability or impairment? E.g. hearing, dyslexia ☐ Yes ☐ No

If yes, please state: _____

MEDICATION

✓ Does this child use any medicine (tablets, inhalers, creams or injections) ☐ Yes ☐ No

ALLERGIES

✓ Is this child allergic to any medicines? ☐ Yes ☐ No

✓ Does this child have any other allergies? E.g. strapping tape or food ☐ Yes ☐ No

If yes, please state: _____

What was this child's reaction _____ When _____

✓ This child lives with:

☐ Mother ☐ Grandparents ☐ Boarder/Flatmate

☐ Father ☐ Siblings ☐ Other _____

Height today _____ Weight today _____

School / ECE (Early Childhood Education) Centre : _____

Signature: Date: Next of Kin: _____

Name: Relationship to child: Contact Number: _____