Brindabella
Family Practice

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		Last Name:_____ **First Name:**_____ **Date of Birth:** _____

New Patient Questionnaire – Children < 16

To assist us to provide good medical care, please answer these questions. *Use the reverse side if more space needed.*

CURRENT HEALTH

List your **allergies**	☐ No Known Allergies
What was the reaction?	
List year of allergy	
School name & grade	

PLEASE LIST YOUR FAMILY -

	Mother	**Father**	**Sibling 1**	**Sibling 2**	**Sibling 3**	**Sibling 4**
Name						
Year of Birth						

FAMILY HISTORY Please list any diseases in your family *Use over if you need it.*
(Asthma, Blood Pressure, Cancer, Diabetes, Epilepsy, Heart disease, Thyroid disease, Stroke etc)

Mother		Grand mother	
Father		Grand father	
Brother		Grand mother	
Sister		Grand father	

PAST HEALTH

List any **operations** &year	
List **disease/illness** &year	
List ALL **medication** taken - now & occasionally, include contraception/vitamins	

IMMUNISATIONS

Please circle the immunisations that the child has had: **2 mth 4 mth 6 mth 12 mth 18 mth 4 year**

Has the child had any of the following immunisations Hepatitus B (a course of 3) Chicken Pox (Varicella)
Pneumococcal (Prevnar) Meningcoccal (Menjugate)

BIRTH HISTORY (for babies only)

Was the pregnancy normal? Yes / No Was the labour normal? Yes / No Birth weight _____ Kg