Clinical Information for Children 16 and Under (Please give this sheet to the Doctor or Nurse)

As a new patient, completing this form helps us get a detailed overview of your health. This form is confidential and will only be kept in your confidential medical record.

Name: ______________________________ **Date of Birth:** ______/_____/__________

Please tick routine immunisations received:

Birth ☐ **2 months** ☐ **4 months** ☐ **6 months** ☐ **12 months** ☐ **18 months** ☐ **4-year-old** ☐

Any health problem during pregnancy/delivery:

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Any past or current health/developmental issues:

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Any operation/surgery in the past:

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Any hospital admissions:

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Any medical problems run in child's family: (e.g. diabetes, asthma, eczema, bleeding/clotting disorder, cancer...)

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Allergies to medications or other substances:

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List of your current medication: (Including over the counter remedies)

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