Claypath & University
Medical Group

Confidential Medical History Questionnaire
Child Under 14 Years

The contents of this questionnaire are confidential and will be used as part of your medical record. Please use *BLOCK CAPTIALS* to make the form easier for us to read.

Personal Details

Surname	
First Name (s)	
Assigned Gender What was your gender assigned at birth	Male / Female
Title e.g. Mr, Mrs	
Date of Birth	
Home Address	
Email Address Please write in capitals	
Mobile Phone	
Home Phone	
Ethnic Origin (optional)	
First Spoken Language	
Place and Country of Birth	

Next of Kin

We will only use this information in an emergency and will not disclose information to them

Name	
Relationship to you	
Telephone	
Address If different to your own	

Personal History

Significant Medical Conditions This includes long term conditions, serious illnesses you have had or major operations. Please continue onto a blank sheet of paper if needed Please include conditions such as: Asthma, Epilepsy, High blood pressure, Diabetes, Thyroid problems, Cancer	
Allergies	
Current Medication Please list all regular medication you take. Please continue onto a blank sheet of paper if needed	

Vaccination History

Please complete the boxes below with the dates of the vaccinations that you have had. If you have not received the vaccination, please write "NA". If you are not sure, please write "Not Sure".

	1st Dose	2nd Dose	3rd Dose	4th Dose	Booster
6-in-1 vaccine Dip/tet/polio/pertussis/hib/hep B					
Meningitis B					
Rotavirus					
Pneumococcal (PCV) Meningitis					
MMR					
Hib/Men C					
Pre-School Booster (4-in-1)					
Human Papilloma Virus (HPV)					
3-in-1 Teenage Booster Td/IPV vaccine					
Hepatitis B Isolated vaccine, do not include 6-in-1					
BCG					

Any other vaccinations There is no need to list annual flu or COVID vaccines	