PEARCEDALE MEDICAL CENTRE

Reset

MEDICAL HISTORY – CHILDREN 15 & UNDER
CLINICAL INFORMATION

(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: _____

If possible, please bring to the consultation:

- ☐ Records of childhood (and travel) vaccinations
- ☐ Child Health Record (for pre-school children or if otherwise relevant)
- ☐ Asthma Management Plan, if relevant

Please tick routine immunisations received

☐ Birth ☐ 2 months ☐ 4 months ☐ 6 months ☐ 12 months ☐ 18 months ☐ Four year old

Your child's current or past health or developmental problems (*please mark*)

Any major problems during pregnancy or soon after birth?	Yes ☐ No ☐	Spina bifida	Yes ☐ No ☐
Skin problems: eczema/seborrheic dermatitis/other	Yes ☐ No ☐	Cerebral palsy	Yes ☐ No ☐
Diabetes	Yes ☐ No ☐	Autism/Asperger's	Yes ☐ No ☐
Vision or eye problems	Yes ☐ No ☐	ADHD or behavioural disorder	Yes ☐ No ☐
Deafness or concern about hearing	Yes ☐ No ☐	Anxiety/depression/obsessive compulsive disorder/ other mental health problem	Yes ☐ No ☐
Recurrent ear infections	Yes ☐ No ☐		
Asthma/other lung problems If asthma: Does your child have a current Asthma Management Plan?	Yes ☐ No ☐	Teeth/gum problems Does your child see a dentist regularly?	Yes ☐ No ☐
Coeliac disease/lactose intolerance/other malabsorption	Yes ☐ No ☐	Concerns about bed-wetting? Other toileting concerns?	Yes ☐ No ☐
Seizures/epilepsy	Yes ☐ No ☐	Constipation	Yes ☐ No ☐
Kidney problems/ recurrent urinary infections	Yes ☐ No ☐	Concerns about speech and language development?	Yes ☐ No ☐
Cancer/ leukaemia	Yes ☐ No ☐	Learning difficulties	Yes ☐ No ☐
Arthritis	Yes ☐ No ☐	Concerns about other aspects of development?	Yes ☐ No ☐
Unusual or severe infection/ meningitis	Yes ☐ No ☐	Concerns about obesity?	Yes ☐ No ☐
Migraine or severe headache	Yes ☐ No ☐	Operations/surgery (please list)	Yes ☐ No ☐
Head injury	Yes ☐ No ☐		

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Name: Date of birth:

Have any family members had any of the following ?

Childhood or early adulthood cancer (incl skin cancer) Type(s):	Yes ☐ No ☐	Hereditary conditions or those detected at birth or that run in the family:	Yes ☐ No ☐
Anxiety/depression/suicide	Yes ☐ No ☐	Asthma/eczema/hay fever:	
Other serious childhood illness you are concerned about (any detail):	Yes ☐ No ☐	Some clinical problems are more (or less) likely to occur in people of particular ethnic backgrounds. If you wish us to be aware of your child's ETHNIC ORIGINS, please record here	Yes ☐ No ☐

SCHOOL attended:

MEDICATION LIST including over-the-counter remedies

NAME	STRENGTH	DOSES	REASON

ALLERGIES TO MEDICATION:

OTHER SIGNIFICANT ALLERGIES (e.g. to nuts, eggs):

CARE ARRANGEMENTS and confidentiality

PLEASE ADVISE who the child primarily lives with (*mum / dad / both parents / stepmother / stepfather / foster parent etc.*):

And the name and relationship of any other parent/ carer that the child lives with or is involved with: