***Brecon Medical Group Practice***

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**UNDER 16s QUESTIONNAIRE**

To be completed in conjunction with Form GMS1W (Family Doctor Services Registration)

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| **Personal Details of Child** |
| **Surname:** | **Forename(S):** |
| **Address:****Postcode:** |
| **Telephone Contact Details:** | **Landline:****Mobile:** |
| **Date of Birth:** | **Male/Female:** |
| **Ethnicity** (Please circle appropriate option): | **White / Black / Nepalese / Asian** **Chinese / Eastern European** **South American / Mixed Race / Other** |
| **First Language if applicable:** |  |
| **Name of School attended if applicable:** |  |
| **Details of Next of Kin** |
| **Relationship to Child:** |  |
| **Address:** |  |
| **Telephone Contact Details:** |  |
| **Details of Person with Parental Responsibility** (named on birth certificate or awarded by Court of Law) |
| **Name of person with Parental Responsibility:** |  |
| **Relationship to Child** |  |
| **Details of Main Carer** |
| **Full Name of Main Carer:** |  |
| **Relationship to Child:** |  |
| **Telephone Details of Main Carer:** | **Landline:****Mobile:** |
| **First Language of Carer:** |  |
| **Medical History of Child** |
| **Birth Weight:** |  |
| **Problems at birth** (please specify) |  |
| **Please provide details of any developmental problems:** |  |
| **Please list any illnesses or operations**  |  |
| **Please indicate any allergies:** |  |
| **Please list any current Medications: (Or supply a copy of the current medication list)**  |  |
| **Please indicate any allergies to medication:** |  |
| **Medical Problems of Child** (Please tick if applicable) |
| Asthma | **Yes/No** | Diabetes | **Yes/No** |
| Thyroid Disease | **Yes/No** | Heart Disease | **Yes/No** |
| Epilepsy | **Yes/No** | Other | **Yes/No** |
| **Please provide details of other problems:** |
| **Family Medical History** Are any of the closest family members affected by (please circle) |
| Asthma | Diabetes |
| Glaucoma | Heart Disease |
| Blindness | Tuberculosis |
| Cancer – Please indicate type if known): |
| Infectious Diseases (Please specify): |
| Other (Please specify): |
| **IMMUNISATION HISTORY**  | **DATE GIVEN** |
| **1st DTP/Polio** |  |
| **2nd DTP/Polio** |  |
| **3rd DTP/Polio** |  |
| **1st Hib**  |  |
| **2nd Hib** |  |
| **3rd Hib** |  |
| **1st Men C** |  |
| **2nd Men C** |  |
| **Pre School Booster** |  |
| **MMR** |  |
| **Hib** |  |
| **Other** (Please specify) |  |
| **ANY OTHER RELEVANT INFORMATION** |
| **Please add any information that you think the Doctor should be aware of:** |
| **Thank you for your time in completing this questionnaire.** |
|  |
| **ADMINISTRATION USE ONLY** | **DATE** |
| Form Scanned: |  |
| Task sent to GP to review form and ask whether appointment required to be seen: |  |