

Name: \_\_\_\_\_ Surname: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Allergies**

Do you have any allergies or are you sensitive to drugs or dressings? YES / NO

If yes please specify:

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**Medical Conditions** (past and present)


**Operations** (please include the year)


**Medications** (Current medications including over the counter medications and supplements)

Medication	Strength	How many per day	What time of day

**Family Medical History** (past and present)

E.g. Cancer, Heart Disease, Diabetes, Mental Health issues, Stroke, Asthma, Eczema


**Birth History**

Was your child born at full term (38+ weeks)	
Any complications during pregnancy or birth:	

**Vaccinations**

Has your child had the following vaccinations? (Please circle)

Birth (Hep B)	Yes / No	12 months	Yes / No
2 months	Yes / No	18 months	Yes / No
4 months	Yes / No	4yrs	Yes / No
6 months	Yes / No	other	Yes / No

**Social History**

How many siblings?	
Does your child attend day care, kindergarten or school (which grade):	
Has your child had any delay with development:	
Any hearing or vision problems:	

*Office Use Only*

 Height:           cm    Bp:       /           BSL:           (if applicable - at risk, family hx, ?bloods)  
 Weight:           kgs   Pulse:           Temp: