

KINGUSSIE MEDICAL PRACTICE

Dr Alastair Michie • Dr David Pinney • Dr Heather Druett • Dr Mary Couldbeck

Ardvonie Park, Gynack Road, Kingussie PH21 1ET
T: 01540 661233 • E: nhsh.gp55930-admin@nhs.scot • W: kingussiemedicalpractice.co.uk

Child Health Questionnaire

Private and Confidential

Welcome to the Kingussie Medical Practice, thank you for completing this child health questionnaire.
Please fill in as many details as possible.

| | |
|-------|--|
| Date: | |
|-------|--|

Please Use Block Capitals

PERSONAL DETAILS:

| | |
|----------------|-------------|
| Surname: | First Name: |
| Second Name: | Known As: |
| Date of Birth: | |

CONTACT DETAILS:

| | |
|--|--------------------------------|
| Parent/Guardian Mobile Number: | Parent/Guardian Mobile Number: |
| Parent/Guardian Email Address: | Parent/Guardian Email Address: |
| Emergency Contact Name: | Emergency Contact Number: |
| Emergency Contact's Relationship to the Child: | |

CHILD PLAN:

| | | |
|------------------------------------|-----|----|
| Does your child have a child plan? | Yes | No |
|------------------------------------|-----|----|

MEDICATION:

| |
|--|
| IS THE CHILD ON ANY CURRENT MEDICATION: <i>If yes please list below</i> |
| Medication Name and Dose: |
| |
| |
| |
| |
| |
| |

IMMUNISATION HISTORY: *or provide copy of Red Book*

| TYPE | DOSE | Date Given |
|--|------------------------------|------------|
| DTaP / IPV / Hib | 1 st Dose | |
| | 2 nd Dose | |
| | 3 rd Dose | |
| DTaP/IPV | 4 th Dose/Booster | |
| Pneumococcal (PCV) | 1 st Dose | |
| | 2 nd Dose | |
| | 3 rd Dose | |
| Meningitis C | 1 st Dose | |
| | 2 nd Dose | |
| MMR | 1 st Dose | |
| | 2 nd Dose | |
| Rotavirus | 1 st Dose | |
| | 2 nd Dose | |
| HiB/MenC | | |
| Flu Vaccine | | |
| Other e.g. HepB, BCG etc. (please list below): | | |

ETHNICITY:

Although we are all individual people, our racial and ethnic backgrounds may place us at differing risks for some diseases. We are collecting race, ethnicity, and language information from **all of our patients** to help us get to know them better. By knowing more about your racial and ethnic background, we can get a better idea of health risks you may have and better meet your health needs. Your information is kept private and confidential and is protected by law. The only people who will see your information are members of your care team and others who are authorized to see your medical record.

Please choose one section, then tick one box that best describes your ethnic group or background.

| | | | | | |
|---|--|---------------|--|----------------|--|
| I do not wish to state my Ethnic Group, please sign here: _____ | | | | | |
| Bangladeshi | | Black African | | Black British | |
| Black Caribbean | | Black Other | | Chinese | |
| Indian | | Other Asian | | Pakistan | |
| White British | | White Irish | | White Scottish | |
| Other | | | | | |