



Clinical Information for Children 16 and Under

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: ____ / ____ / ____

Please tick routine immunisations received:

Birth 2 months 4 months 6 months 12 months 18 months 4-year-old

Any health problem during pregnancy/delivery:

Any past or current health/developmental issues:

Any operation/surgery in the past:

Any hospital admissions:

Any medical problems run in child's family: (e.g. diabetes, asthma, eczema, bleeding/clotting disorder, cancer...)

Allergies to medications or other substances:

List of your current medication: (Including over the counter remedies)
