RICHMOND HEALTH CENTRE

Child New Patient Questionnaire

Please complete the information below to help us identify any problem areas.

Name: ..... Date of Birth: .....

Name of person completing form : .....Parent/Guardian

Known Medical Problems/Surgery or recurring illnesses:	**Is there any Family History we should be aware of: Yes/No** ....
Is your child on any regular medication? **Yes / No** **Please list their current medications:** **.....** **.....** **.....** **.....** **.....**	**Has your child been immunised?** **Yes / No** **Please provide a copy of your childs immunisations**
Does your child have any allergies? **Yes / No** **.....** **.....**	