



**Health Questionnaire**

(Please fill in this questionnaire as accurately and detailed as possible. Fax it or post it as below)

Name.

Date of Birth (dd/mm/yyyy).

Address.


Telephone Numbers:

Landline

Mobile

GP name and Address:


e-mail address:

Current Medical History (Do you / your child have any on-going medical problems or complaints?):

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Medication and vaccination history (Please list any medicines and / or vaccines you or your child has had with approximate dates as accurately as possible):

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Past Medical History (Did you / your child have any hospital admissions, operations or other significant medical events in the past?):

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Allergy or adverse reaction history (Please describe if you / your child experienced any abnormal reactions to any medications, foods or other substances):

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Relevant Family History (Does anybody you are directly related to have a history of relevant medical problems?):

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Any other information (Please add any other information or thoughts that you think may be in any way relevant to the diagnosis or treatment):

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