BRAIDS MEDICAL PRACTICE
NEW PATIENT QUESTIONNAIRE
Under 5 years ONLY

Please complete, as fully as possible for your child.

Thank you in anticipation:

Full name: ....

Address:..

Telephone Number:...

Date of birth:..

Ethnic origin: ....

Is your child registered at school:...

If so which school:……………………………………………………....

FAMILY HISTORY

Have any of your child's family had any of the illnesses listed below?

Diabetes	Yes/No	Asthma	Yes/No
High blood pressure	Yes/No	Epilepsy	Yes/No
Arthritis	Yes/No	Depression	Yes/No
Heart disease	Yes/No		
Chronic bronchitis	Yes/No		

Allergies ....

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