New Patient Medical Questionnaire
For Children Under 16 Years

Please complete and submit one form for each **child** member of your family. If you are unsure how to answer a section or need assistance with completing the form please talk with reception.

* Answers are required for all questions marked with an asterix

Personal Information

Patients Full Name*					
Date of Birth*	/ /				
Email*					
Guardian/Caregiver – Are you completing on behalf of the patient?		Yes	*If yes,* Your Full Name		
	Relationship with Patient			Phone	

Accessibility and Support

Do you or your child need help with mobility / hearing / vision / speaking?*		No		Yes
Please tick all that apply				
◯ Wheelchair	◯ Walking aid	◯ Hearing Aid	◯ Glasses/ Contacts	
◯ Sign language	◯ Lip reading	◯ Braille	◯ Other:	
How else can we help or support you or your child?				

Does the child or parent/guardian require an interpreter?*		No		Yes
Which language?				

Child Current and Past Medical History

Does your child take any medication?		Yes		No	*Please explain*
Does your child have any allergies to medication or food?		Yes		No	*Please explain*
Does your child have any serious or chronic illnesses?		Yes		No	*Please explain*
Has your child had any serious injuries/ accidents, any surgeries or been hospitalised?		Yes		No	*Please explain*

Does your child currently have, or previously had any of the following? Tick all that apply			
Seizures		Frequent abdominal pain or constipation requiring doctors visit	
Illnesses/ problems during pregnancy of the child		Bladder / kidney problems / bedwetting	
Asthma, bronchiolitis, or respiratory issues		Anemia or bleeding problems	
Nasal allergies or eczema		Diabetes ◯ Type 1 ◯ Type 2 ◯ Unsure	

Frequent ear infections or sore throats		Mental health issues	
Problems with eyes, vision, or teeth		ADD / ADHD	
Frequent headaches or other neurological problems		Autism spectrum disorder	
Thyroid or other gland problems		Developmental delay	
Heart problems / murmur		Other	

Family Medical History (Parents, Siblings or Children)

Have any family members had any of the following. Tick all that apply			
Alcohol or drug abuse		Kidney or liver disease	
Congenital birth defects		Gastrointestinal or stomach disorders	
Allergies		Seizure disorder/ epilepsy	
Asthma or lung disease		Migraine headaches	
Mental health history or issues		Ear / nose / throat disorders	
Diabetes ◯ Type 1 ◯ Type 2 ◯ Unsure		Eye disorders	
Obesity or metabolic disorder		Thyroid disorder	
Cancer		Joint problems	
Blood disorders		Skin disorders	
Heart disease, heart attack or stroke			
High blood pressure		Other	

Screening

Has your child ever had a hearing screen?		No		Yes		Don't know
Results if known:						
Has your child ever had a vision screen?		No		Yes		Don't know
Results if known:						
If 4yr or older, has your child had a B4 School Check?		No		Yes		Don't know

Immunisations

Has your child been **immunised**? *Please bring any records to first consult*		No		Yes		Don't know
If yes, where was your child immunised? ◯ In NZ ◯ Overseas ◯ Both in NZ and overseas						
Has your child ever received a **Flu** vaccine?		No		Yes		Don't know
Has your child ever received a **COVID-19** vaccine?		No		Yes		Don't know
If over 9 years, has your child ever received the **human papilloma virus (HPV)** vaccine series?		No		Yes		Don't know
Has your child ever reacted to immunisations		No		Yes		Don't know

Lifestyle – for 15 years and over

Smoking/ Vaping What is your current status? **Tick all that apply**	◯ **Never smoked / not applicable**					
	◯ **Ex-smoker**	What year did you start smoking/vaping?				
		Average number of cigarettes smoked per day?				
	◯ **Current Smoker**	Year you started smoking				
		Average cigarettes smoked per day				
		Do you consent for our staff to refer you to the Quit service?		Yes		No
	◯ **Current vaper**					

Family Social Situation

Please list all those living in the childs home:		
Name	Relationship to Child	Date of Birth

Are there any **custodial arrangements** concerning your child?		No		Yes
	If Yes, explain the arrangements, list parent/guardians:			
If age <5 yr, does your **child attend childcare**?		No		Yes

Living Situation	What is your living situation today?	◯ The child has a steady place to live ◯ The child has a place to live today, but I am worried about losing it in the future ◯ The child does not have a steady place to live (They are temporarily staying with others, in a shelter, motel, hotel, in a car or on the street)				
	Does **anyone in the household smoke cigarettes or vape**?			Yes		No
	Do you, as the parent/ guardian have concerns about any of the following problems in the place the child is currently living? **Select all that apply**	◯ Pests (bugs, ants, mice) ◯ Mould ◯ Lack of heat	◯ Water leaks ◯ None of the above ◯ Other			
		If Other, please state:				
Food Availability	In the past 12 months have as the parent/guardian worried that your food might run out before you had money to buy more?	◯ Never ◯ Sometimes ◯ Often				
Transportation	In the past 12 months has lack of reliable transportation kept your family from medical appointments, meetings, work or getting things needed for daily living?			Yes		No