SUNNYNOOK • MEDICAL CENTRE •

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	◯Lipreading	◯ 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/bed wetting				
Asthma, bronchiolitis, or respiratory issues		Anemia or bleeding problems				
Nasal allergies or eczema		Diabetes	◯ Type1	◯Type2	◯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 ◯ Type1 ◯Type2 ◯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 4 yr 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 papillomavirus (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 child's 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 <5yr, 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 o fheat		◯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