Breakspear Hospital

CHILD MEDICAL QUESTIONNAIRE

Please complete all the white boxes and bring the completed form and your child's Developmental Book to the initial consultation.

Date of first appointment (dd/mm/yyyy)

Child's details:

Child's first name

Child's last name

☐ Male ☐ Female

Date of birth (dd/mm/yyyy)

Height (centimetres)

Weight (kilograms)

Address

Post code

Parent's/Guardian's details:

First name

Last name

Contact number

Alternative

Child's GP name

GP address

GP contact number

Child's condition:

Does your child have immune deficiencies? ☐ Yes ☐ No

Please describe your child's main symptom(s).

Please describe any other known conditions.

Child's environment and diet details:

	Yes	No		Yes	No		Yes	No
Does your child live in the country?	☐	☐	Does your child live near a main road?	☐	☐	Are there any smokers in the household?	☐	☐
Is there gas in the home?	☐	☐	Are there coal fires in the home?	☐	☐			
Does your child eat regularly?	☐	☐	How many times per day does your child eat ?			Was your child bottle fed?	☐	☐
Does your child have a poor appetite?	☐	☐	→ If yes, please describe.					
Is there any food that your child eats at least once a day or craves?	☐	☐	→ If yes, please list.					
Is there any food that makes your child ill?	☐	☐	→ If yes, please list.					
Is there any food that you avoid giving your child because it disagrees with him/her?	☐	☐	→ If yes, please list.					

Please tick the following that apply to your child and/or anyone in the child's immediate biological family:

	Your Child	Child's family		Your Child	Child's family
Asperger Syndrome	☐	☐	Thyroid problems	☐	☐
Eczema	☐	☐	Arthritis	☐	☐
Crohn's Disease	☐	☐	Lupus	☐	☐
Diabetes	☐	☐	Pernicious anaemia	☐	☐
Asthma	☐	☐	Addison's disease	☐	☐
Heart problems	☐	☐	Autism	☐	☐

Other illness (please describe):

Please enter the appropriate value for each of the following symptoms using the following point system:

0 = Never/almost never has the symptom
1 = Occasionally has it, effect is not severe
2 = Occasionally has it, effect is severe
3 = Frequently has it, effect is not severe
4 = Frequently has it, effect is severe

	Points:		Points:
Wheezing / Coughing		Bedwetting / soiling (if toilet trained)	
Running nose		Incontinence	
Catarrh		Frequent urination	
Sneezing		Pain on passing urine	
Sniffing		Excessive thirst	
Recurrent earache		Total:	
Frequent throat infections			
Nasal "crease" (line across nose)		Mouth ulcers	
Nose rubbing		Coated tongue	
Itching inside the ears		Patchy, sore tongue	
Total:		Bad breath	
		Hiccups	
Skin rashes		Abdominal pain	
Skin itching		Abdominal bloating	
Dry skin		Diarrhoea	
Skin infections		Constipation	
Total:		Total:	
Hyperactivity		Dark circles beneath the eyes	
Tantrums		Abnormal "milestones"	
Mood swings		Unexplained crying	
Abnormal sleep pattern		Aching legs	
Night terrors		Joint pain / swelling	
Poor concentration		Low weight	
Headaches		Abnormal weight	
Talkativeness		Redness of the ears	
Sudden sleeping		Puffiness around the eyes	
Total:		Total:	

Grand Total