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Child Registration

Child's Personal Details

A complete medical history is important for us to provide you with optimum health care. Please discuss anything you are unsure of with your doctor.

Title: _____ Surname: _____ First Name: _____

Date of Birth: ____/____/____

Address: _____ Suburb: _____

Phone Home:_____ Work:_____ Mobile: _____

Email: _____

Do you consent to receiving information about Wellness Medicine via email? (circle) Yes/ No

Medicare Number: __ __ __ __ __ __ __ __ __ __ __ Expiry __ __/ __ __ PRN No. ____

Aboriginal/Torres Strait Islander: YES / NO

Emergency contact/ Next of Kin: _____ Contact Number: _____

School _____ Year: _____

Previous Doctor: _____ Address: _____

Other family members attending this practice: _____ Any custody issues? _____

Medical History

Is your diet (circle): Poor / Fair / Good

(If vegetarian) do you eat dairy, eggs or fish? _____

Do you exercise regularly? No / Yes How many days a week do you exercise? _____

What type of exercise do you do? _____

Sign here to indicate that you are providing true and correct information, and that you have read and accepted our **Patient Privacy Policy and Cancellation Fee Policy.**

Signature patient/guardian: _____ Date: ____ /____/____

Transfer of Health Information:

You may have consistently consulted with a GP at another practice. The health information held by the GP may assist us with your future health care needs. You may wish to have a copy or a summary of your health records transferred to this practice. Please ask receptionist for information about how this can take place.

Does your child have any allergies to medicines or anything else (circle)? NO / YES

To what? _____ Reaction?: _____

Current Medications (including over the counter medication)

Name of medication	Strength	Times taken

Has your child ever had any major operations or been admitted to hospital/ seen a specialist?

Year	Reason

Pregnancy

Any problems in pregnancy (circle)? YES / NO _____

Born on time (circle)? YES / NO _____

Mode of delivery (circle): normal, forceps, ventouse, caesarean (planned / unplanned)

Any problems at birth (circle)? YES / NO special care admission / feeding problems / jaundice

Any physical abnormalities detected at any stage (circle)? YES / NO _____

Preventative Health

Has your child ever had?

Heart Problems (circle)	Year began	Active now	Serious Infection (circle)	Year began	Active now
Liver disease, Jaundice, Hepatitis			Skin rashes, dermatitis, eczema, psoriasis		
Pancreatitis			Epilepsy/fits/ blackouts/ strokes		
Hernia/ bowel problems			AIDS		
Diabetes			Asthma/ Emphysema		
Thyroid problem			Hay fever/ sinus problems		
Kidney/ urine/ bladder problems			Eye/ ear problems		
Arthritis/ Joint problems			Back/neck problems		
Cancer – where?			Serious trauma		

Other:					

Immunisation

Immunisation (circle) normal schedule / modified

Did your child have all his/her normal childhood vaccinations? (circle) YES / NO

Has your child had a tetanus booster? (circle) YES / NO when?Has your child had any additional vaccinations? E.g. for travel

If so what and when? _____

	Year		Year		Year
Birth		**6 month**		**4 year**	
2 month		**12 month**		**Year 7**	
4 month		**18 month**		**Year 10**	

Immunisation:	Year	Immunisation:	Year
Tetanus		**Chicken Pox**	
Rubella		**Influenza**	
Hepatitis A		**Pneumonia**	
Hepatitis B		**Measles**	
Meningococcal		**Cholera**	
Typhoid			

Family History:

Has anyone related to you ever had:	TYPE	Relationship to you	Ever had ☑	Age of onset	Died from ☑	AGE
High blood pressure						
High cholesterol						
Heart attack/angina						
Stroke						
Anaemia						
Bleeding disorder						
Asthma/ emphysema						
Tuberculosis						
Arthritis						
Diabetes						

Kidney disease						
Cancer or tumour						
Depression/anxiety						
Mental Health disorder						
Thyroid problems						
Other						