North Shore Paediatric Allergy Centre Patient Questionaire

Name of Child:_____ DOB: ____ _____

No of siblings: ____ Next of Kin/Emergency Contact: _____

Address:_____

School: _____School year: _____

Medicare number: _____ [__] Expiry date: _____

Health Fund: _____ Number: _____ Type of Cover_____

Nationality:_____

Usual GP: _____

How did you hear about this clinic: _____

Parent/Guardian responsible for account:

Name: _____ DOB:_____

Medicare number: _____ [__]Expiry date: _____

Relationship to child: _____

Address: _____

Telephone number: H: _____ W: _____M:_____

Email address: _____Consent for email/sms reminders or recall Yes / No

Mother's Details:

Name: _____ _____

Marital Status: _____

Address:_____

Contact no: H: _____

W:_____

M:_____

Nationality: _____

Family History of Allergy - please circle

Asthma: past present never

Hay fever: past present never

Eczema: past present never

Food allergies: past present never

Other (please specify):

Father Details_____

Name: _____

Marital Status: _____

Address: _____

Contact no: H: _____

W: _____

M: _____

Nationality: _____

Family History of Allergy - please circle

Asthma: past present never

Hay fever: past present never

Eczema: past present never

Food allergies: past present never

Other (please specify):

Please turn over

Name Sibling 1: _____Age: _____

History of Allergy - please circle

Asthma: past present never

Hay fever: past present never

Eczema: past present never

Food allergies: past present never

Other (please specify):

Name Sibling 2: _____Age: _____

History of Allergy - please circle

Asthma: past present never

Hay fever: past present never

Eczema: past present never

Food allergies: past present never

Other (please specify):

Name Sibling 3: _____Age: _____

History of Allergy - please circle

Asthma: past present never

Hay fever: past present never

Eczema: past present never

Food allergies: past present never

Other (please specify):