

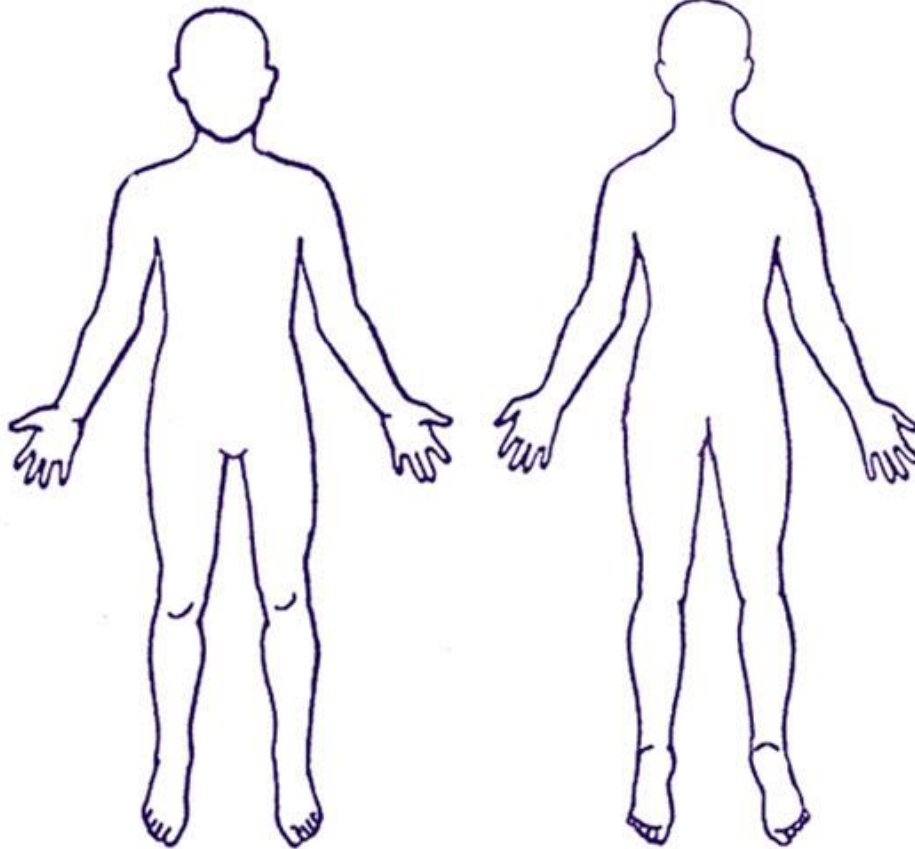
English	Chinese (Mandarin) / 英语
<p>Patient Questionnaire for newly arrived migrants in the UK: Children and Young People</p>	<p>针对英国新移民——儿童和青少年的全新患者问卷调查</p>
<p>Everyone has a right to register with a GP. You do not need proof of address, immigration status, ID or an NHS number to register with a GP</p> <p>This questionnaire is to collect information about children's health so that the health professionals at your GP practice can understand what support, treatment and specialist services they may need in accordance with the confidentiality and data sharing policies of the National Health Service.</p> <p><b>Competent young people aged under 18 may complete the adult version for themselves.</b></p> <p>Your GP will not disclose any information you provide for purposes other than your direct care unless: you have consented (e.g. to support medical research); or they are required to do so by law (e.g. to protect other people from serious harm); or because there is an overriding public interest (e.g. you are suffering from a communicable disease). Further information about how your GP will use your information is available from your GP practice.</p> <p>Return your answers to your GP practice.</p>	<p>每个人都有权进行全科医生注册。进行全科医生注册时不需要地址证明、移民身份、身份证，或 NHS 号码</p> <p>本问卷旨在收集您健康的信息，以便您所在诊所的医疗专业人员能够根据英国国家医疗服务体系的保密和数据共享政策了解您所需的支持、治疗，和专业服务。</p> <p><b>条件优秀的 18 岁以下年轻人可完成成人版问卷。</b></p> <p>除了对您进行直接护理时，您的全科医生不会披露您的任何信息，但以下情况除外：已获取您的同意（例如支持医学研究）；或者法律要求他们必须披露信息（例如，为了保护他人免受严重伤害时）；或者涉及到极其重要的公共利益时（例如，您患有传染病）。关于全科医生会如何使用您的个人信息，您可以在您所在的诊所查看更多相关资料</p> <p>将您的答案提交给您所在的诊所。</p>

Person completing	被调查人
Who is completing this form: <input type="checkbox"/> Child's Parent <input type="checkbox"/> Child's legal guardian/carer	谁会填写这个表格: <input type="checkbox"/> 儿童的父母 <input type="checkbox"/> 儿童的监护人/护理人
Section one: Personal details	第一部分：个人资料
Child's full name:	儿童的姓名：
Child's date of birth: Date _____ Month _____ Year _____	儿童的生日： 日 _____月 _____年 _____
Child's address:	儿童的地址：
Mother's name:	母亲姓名
Father's name:	父亲姓名
Contact telephone number(s):	电话：
Email address:	邮箱：
<b>Please tick all the answer boxes that apply to your child.</b>	请勾选所有符合您子女情况的选择项

<p>1.1 Which of the following best describes your child:</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Prefer not to say</p>	<p>1.1 哪项描述符合您子女的个人情况?</p> <p><input type="checkbox"/> 男性</p> <p><input type="checkbox"/> 女性</p> <p><input type="checkbox"/> 其他</p> <p><input type="checkbox"/> 不想说</p>
<p>1.2 Religion:</p> <p><input type="checkbox"/> Buddhist</p> <p><input type="checkbox"/> Christian</p> <p><input type="checkbox"/> Hindu</p> <p><input type="checkbox"/> Jewish</p> <p><input type="checkbox"/> Muslim</p> <p><input type="checkbox"/> Sikh</p> <p><input type="checkbox"/> Other religion</p> <p><input type="checkbox"/> No religion</p>	<p>1.2 宗教 :</p> <p><input type="checkbox"/> 佛教</p> <p><input type="checkbox"/> 基督教</p> <p><input type="checkbox"/> 印度教</p> <p><input type="checkbox"/> 犹太教</p> <p><input type="checkbox"/> 伊斯兰教</p> <p><input type="checkbox"/> 锡克教</p> <p><input type="checkbox"/> 其他</p> <p><input type="checkbox"/> 无</p>
<p>1.3 Main spoken language:</p> <p><input type="checkbox"/> Albanian</p> <p><input type="checkbox"/> Arabic</p> <p><input type="checkbox"/> Dari</p> <p><input type="checkbox"/> English</p> <p><input type="checkbox"/> Persian</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Russian</p> <p><input type="checkbox"/> Tigrinya</p> <p><input type="checkbox"/> Ukrainian</p> <p><input type="checkbox"/> Urdu</p> <p><input type="checkbox"/> Vietnamese</p>	<p>1.3 主要语言:</p> <p><input type="checkbox"/> 阿尔巴尼亚语</p> <p><input type="checkbox"/> 阿拉伯语</p> <p><input type="checkbox"/> 达里语</p> <p><input type="checkbox"/> 英语</p> <p><input type="checkbox"/> 波斯语</p> <p><input type="checkbox"/> 其他</p> <p><input type="checkbox"/> 俄语</p> <p><input type="checkbox"/> 提格里尼亚语</p> <p><input type="checkbox"/> 乌克兰语</p> <p><input type="checkbox"/> 乌尔都语</p> <p><input type="checkbox"/> 越南语</p>
<p>1.4 Second spoken language:</p> <p><input type="checkbox"/> Albanian</p> <p><input type="checkbox"/> Arabic</p> <p><input type="checkbox"/> Dari</p> <p><input type="checkbox"/> English</p> <p><input type="checkbox"/> Persian</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Russian</p> <p><input type="checkbox"/> Tigrinya</p> <p><input type="checkbox"/> Ukrainian</p> <p><input type="checkbox"/> Urdu</p> <p><input type="checkbox"/> Vietnamese</p> <p><input type="checkbox"/> None</p>	<p>1.4 第二语言</p> <p><input type="checkbox"/> 阿尔巴尼亚语</p> <p><input type="checkbox"/> 阿拉伯语</p> <p><input type="checkbox"/> 达里语</p> <p><input type="checkbox"/> 英语</p> <p><input type="checkbox"/> 波斯语</p> <p><input type="checkbox"/> 其他</p> <p><input type="checkbox"/> 俄语</p> <p><input type="checkbox"/> 提格里尼亚</p> <p><input type="checkbox"/> 乌克兰语</p> <p><input type="checkbox"/> 乌尔都语</p> <p><input type="checkbox"/> 越南语</p> <p><input type="checkbox"/> 无</p>
<p>1.5 Does your child need an interpreter?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>	<p>1.5 您的子女需要翻译吗?</p> <p><input type="checkbox"/> 是</p> <p><input type="checkbox"/> 否</p>
<p>1.6 Does your child need sign language support?</p> <p><input type="checkbox"/> No</p>	<p>1.6 您的子女需要手语翻译吗?</p> <p><input type="checkbox"/> 否</p> <p><input type="checkbox"/> 是</p>

<input type="checkbox"/> Yes	
<p>1.7 Who lives in the same household as your child now in the UK?</p> <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Brother(s) How many? _____ What age(s)? _____ <input type="checkbox"/> Sister(s) <input type="checkbox"/> How many? _____ <input type="checkbox"/> What age(s)? _____ <input type="checkbox"/> Other <input type="checkbox"/> How many? _____	<p>1.7 在英国，谁与您的子女同住一户人家？</p> <input type="checkbox"/> 母亲 <input type="checkbox"/> 父亲 <input type="checkbox"/> 兄弟 兄弟共几人？ _____ 年龄 _____ <input type="checkbox"/> 姐妹 <input type="checkbox"/> 姐妹共几人？ _____ <input type="checkbox"/> 年龄 _____ <input type="checkbox"/> 其他 <input type="checkbox"/> 共几人？ _____
<p>1.8 Does your child attend nursery or school?</p> <input type="checkbox"/> No <input type="checkbox"/> My child is under 2 years of age <input type="checkbox"/> We have applied for a place but have not yet been allocated a nursery/school <input type="checkbox"/> I would like information on where I can get support to apply for a nursery or school place  <input type="checkbox"/> Yes – <i>please give name of nursery or school</i> _____	<p>1.8 您的子女是否已上学？</p> <input type="checkbox"/> 否 <input type="checkbox"/> 我的子女不满两岁 <input type="checkbox"/> 我们已经报名，但子女尚未入学 <input type="checkbox"/> 我想知道我们要在哪里为子女入学报名  <input type="checkbox"/> 是—— <i>请提供学校名</i> _____
<p>Section two: Health questions</p>	<p>第二部分：健康问题</p>
<p>2.1 Do you have any concerns about your child?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes	<p>2.1 您对子女是否有担忧？</p> <input type="checkbox"/> 否 <input type="checkbox"/> 是
<p>2.2 Is your child currently unwell or ill?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes	<p>2.2 您的子女是否患病或身体不适？</p> <input type="checkbox"/> 否 <input type="checkbox"/> 是
<p>2.3 Does your child need an urgent help for a health problem?</p> <input type="checkbox"/> No <input type="checkbox"/> Yes	<p>2.3 您的子女是否需要紧急治疗？</p> <input type="checkbox"/> 否 <input type="checkbox"/> 是

<p>2.4 Does your child currently have any of the following symptoms? Please tick all that apply</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Weight loss</li> <li><input type="checkbox"/> Cough</li> <li><input type="checkbox"/> Coughing up blood</li> <li><input type="checkbox"/> Night sweats</li> <li><input type="checkbox"/> Extreme tiredness</li> <li><input type="checkbox"/> Breathing problems</li> <li><input type="checkbox"/> Fevers</li> <li><input type="checkbox"/> Diarrhoea</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Skin complaints or rashes</li> <li><input type="checkbox"/> Blood in their urine</li> <li><input type="checkbox"/> Blood in their stool</li> <li><input type="checkbox"/> Headache</li> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Low mood</li> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Distressing flashbacks or nightmares</li> <li><input type="checkbox"/> Difficulty sleeping</li> <li><input type="checkbox"/> Feeling that they want to harm themselves or give up on life</li> <li><input type="checkbox"/> Other</li> </ul>	<p>2.4 您的子女是否具有以下症状？请勾选所有符合事实的选项</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 体重降低</li> <li><input type="checkbox"/> 咳嗽</li> <li><input type="checkbox"/> 咳血</li> <li><input type="checkbox"/> 盗汗</li> <li><input type="checkbox"/> 极度疲劳</li> <li><input type="checkbox"/> 呼吸问题</li> <li><input type="checkbox"/> 发烧</li> <li><input type="checkbox"/> 腹泻</li> <li><input type="checkbox"/> 便秘</li> <li><input type="checkbox"/> 皮肤不适或皮疹</li> <li><input type="checkbox"/> 尿血</li> <li><input type="checkbox"/> 便血</li> <li><input type="checkbox"/> 头痛</li> <li><input type="checkbox"/> 疼痛</li> <li><input type="checkbox"/> 情绪低落</li> <li><input type="checkbox"/> 焦虑</li> <li><input type="checkbox"/> 痛苦回忆或噩梦</li> <li><input type="checkbox"/> 睡眠障碍</li> <li><input type="checkbox"/> 有自杀或自残的想法</li> <li><input type="checkbox"/> 其他</li> </ul>
<p>2.5 Please mark on the body image the area(s) where they are experiencing their current health problem(s)</p>	<p>2.5 请在此躯干图片中标出您认为您的子女出现健康问题的部位</p>



<p>2.6 Was your child born prematurely (delivered early – before 37 weeks/8.5 months of pregnancy)?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>2.6 您的子女是早产儿吗（在目前怀孕 37 周/8.5 个月之前出生）？</p> <p><input type="checkbox"/> 否 <input type="checkbox"/> 是</p>
<p>2.7 Did your child have any health problems soon after delivery e.g. breathing problems, infection, brain injury?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>2.7 您的子女在出生后是否有健康问题？如呼吸苦难，感染，脑损伤</p> <p><input type="checkbox"/> 否 <input type="checkbox"/> 是</p>
<p><b>2.8 New babies only (up to 3 months old):</b> Has your child had a 6-8 week post delivery health check by a GP (doctor)?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p><b>2.8 仅针对新生儿（年龄低于三个月）：</b> 您的子女是否在产后 6-8 周接受过全科医生的健康检查</p> <p><input type="checkbox"/> 否 <input type="checkbox"/> 是</p>
<p>2.9 Does your child have any known health problems?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>2.9 您的子女现在是否有已知的健康问题？</p> <p><input type="checkbox"/> 否 <input type="checkbox"/> 是</p>

<p>2.10 Does your child have any of the following? Please tick all that apply</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Asthma</li> <li><input type="checkbox"/> Blood disorder <ul style="list-style-type: none"> <li><input type="checkbox"/> Sickle cell anaemia</li> <li><input type="checkbox"/> Thalassaemia</li> </ul> </li> <li><input type="checkbox"/> Cancer</li> <li><input type="checkbox"/> Dental problems</li> <li><input type="checkbox"/> Diabetes</li> <li><input type="checkbox"/> Epilepsy</li> <li><input type="checkbox"/> Eye problems</li> <li><input type="checkbox"/> Ears, nose or throat</li> <li><input type="checkbox"/> Heart problems</li> <li><input type="checkbox"/> Hepatitis B</li> <li><input type="checkbox"/> Hepatitis C</li> <li><input type="checkbox"/> HIV</li> <li><input type="checkbox"/> Kidney problems</li> <li><input type="checkbox"/> Liver problems</li> <li><input type="checkbox"/> Mental health problems <ul style="list-style-type: none"> <li><input type="checkbox"/> Low mood/depression</li> <li><input type="checkbox"/> Anxiety</li> <li><input type="checkbox"/> Post-traumatic stress disorder (PTSD)</li> <li><input type="checkbox"/> Previously self-harmed</li> <li><input type="checkbox"/> Attempted suicide</li> <li><input type="checkbox"/> Other</li> </ul> </li> <li><input type="checkbox"/> Skin disease</li> <li><input type="checkbox"/> Thyroid disease</li> <li><input type="checkbox"/> Tuberculosis (TB)</li> <li><input type="checkbox"/> Other</li> </ul>	<p>2.10 您的子女是否有或曾经有过以下症状? 请勾选所有符合事实的选项</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 哮喘</li> <li><input type="checkbox"/> 血液病 <ul style="list-style-type: none"> <li><input type="checkbox"/> 镰状细胞贫血</li> <li><input type="checkbox"/> 地中海贫血</li> </ul> </li> <li><input type="checkbox"/> 癌症</li> <li><input type="checkbox"/> 牙科疾病</li> <li><input type="checkbox"/> 糖尿病</li> <li><input type="checkbox"/> 癫痫</li> <li><input type="checkbox"/> 眼疾</li> <li><input type="checkbox"/> 耳鼻喉</li> <li><input type="checkbox"/> 心脏疾病</li> <li><input type="checkbox"/> 乙肝</li> <li><input type="checkbox"/> 丙肝</li> <li><input type="checkbox"/> 艾滋病</li> <li><input type="checkbox"/> 肾病</li> <li><input type="checkbox"/> 肝病</li> <li><input type="checkbox"/> 心理疾病 <ul style="list-style-type: none"> <li><input type="checkbox"/> 情绪低落/抑郁</li> <li><input type="checkbox"/> 焦虑</li> <li><input type="checkbox"/> 创伤后应激障碍</li> <li><input type="checkbox"/> 曾有自残行为</li> <li><input type="checkbox"/> 曾有自杀行为</li> <li><input type="checkbox"/> 其他</li> </ul> </li> <li><input type="checkbox"/> 皮肤病</li> <li><input type="checkbox"/> 甲状腺疾病</li> <li><input type="checkbox"/> 肺结核</li> <li><input type="checkbox"/> 其他</li> </ul>
<p>2.11 Has your child ever had any operations / surgery?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Yes</li> </ul>	<p>2.11 您的子女是否曾经做过手术?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 否</li> <li><input type="checkbox"/> 是</li> </ul>
<p>2.12 Does your child have any physical injuries due to war, conflict or torture?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Yes</li> </ul>	<p>2.12 您的子女是否在战争, 冲突, 或酷刑中受到过身体伤害?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 否</li> <li><input type="checkbox"/> 是</li> </ul>
<p>2.13 Does your child have any mental health problems? These could be from war, conflict, torture or being forced to flee your country?</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> No</li> <li><input type="checkbox"/> Yes</li> </ul>	<p>2.13 您的子女是否有心理疾病? 原因包括战争, 冲突, 酷刑, 或被迫逃离祖国。</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> 否</li> <li><input type="checkbox"/> 是</li> </ul>

<p>2.14 Does your child have any physical disabilities or mobility difficulties?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>2.14 您的子女是否有残疾或行动障碍?</p> <p><input type="checkbox"/> 否 <input type="checkbox"/> 是</p>
<p>2.15 Does your child have any sensory impairments? Please tick all that apply</p> <p><input type="checkbox"/> No <input type="checkbox"/> Blindness <input type="checkbox"/> Partial sight loss <input type="checkbox"/> Full hearing loss <input type="checkbox"/> Partial hearing loss <input type="checkbox"/> Smell and/or taste problems</p>	<p>2.15 您的子女是否有感官障碍? 请勾选所有符合事实的选项</p> <p><input type="checkbox"/> 否 <input type="checkbox"/> 失明 <input type="checkbox"/> 视力损伤 <input type="checkbox"/> 失聪 <input type="checkbox"/> 听力损伤 <input type="checkbox"/> 嗅觉和/或味觉疾病</p>
<p>2.16 Do you think your child has any learning difficulties or behaviour problems?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>2.16 您的子女是否有学习障碍或行为问题?</p> <p><input type="checkbox"/> 否 <input type="checkbox"/> 是</p>
<p>2.17 Do you have any concerns about your child's growth e.g. their weight/height?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>2.17 您是否担心过子女的成长? 例如身高或体重</p> <p><input type="checkbox"/> 否 <input type="checkbox"/> 是</p>
<p>2.18 <b>Babies only:</b> Is your child experiencing any feeding problems e.g. vomiting, reflux, refusing milk?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p>	<p>2.18 <b>仅针对婴儿:</b> 您的子女在喂食方面是否出现过问题? 例如呕吐, 反流, 拒绝哺乳</p> <p><input type="checkbox"/> 否 <input type="checkbox"/> 是</p>
<p>2.19 Has a member of your child's immediate family (father, mother, siblings, and grandparents) had or suffered from any of the following?</p> <p><input type="checkbox"/> Asthma <input type="checkbox"/> Cancer <input type="checkbox"/> Depression/Mental health illness <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart attack <input type="checkbox"/> Hepatitis B <input type="checkbox"/> High blood pressure <input type="checkbox"/> HIV <input type="checkbox"/> Learning difficulties <input type="checkbox"/> Stroke <input type="checkbox"/> Tuberculosis (TB) <input type="checkbox"/> Other</p>	<p>2.19 您子女的直系亲属(父亲、母亲、兄弟姐妹和祖父母)是否有以下任何一种疾病?</p> <p><input type="checkbox"/> 哮喘 <input type="checkbox"/> 癌症 <input type="checkbox"/> 抑郁/心理疾病 <input type="checkbox"/> 糖尿病 <input type="checkbox"/> 心脏病 <input type="checkbox"/> 乙肝 <input type="checkbox"/> 高血压 <input type="checkbox"/> 艾滋病 <input type="checkbox"/> 学习障碍 <input type="checkbox"/> 中风 <input type="checkbox"/> 肺结核 <input type="checkbox"/> 其他</p>



<p>2.20 Is your child on any prescribed medicines?</p> <p><input type="checkbox"/> No  <input type="checkbox"/> Yes –<i>please list your child’s prescribed medicines and doses in the box below</i></p> <p><b>Please bring any prescriptions or medicines to your child’s appointment</b></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 70%;">Name</th> <th style="width: 30%;">Dose</th> </tr> </thead> <tbody> <tr> <td style="height: 150px;"></td> <td></td> </tr> </tbody> </table>	Name	Dose			<p>2.20 您的子女是否在服用处方药?</p> <p><input type="checkbox"/> 否  <input type="checkbox"/> 是——<i>请在下方框中列出您子女的处方药</i></p> <p><i>请将任意处方药携带至您子女的预约地点</i></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 70%;">姓名</th> <th style="width: 30%;">剂量</th> </tr> </thead> <tbody> <tr> <td style="height: 150px;"></td> <td></td> </tr> </tbody> </table>	姓名	剂量		
Name	Dose								
姓名	剂量								
<p>2.21 Are you worried about running out of any these medicines in the next few weeks?</p> <p><input type="checkbox"/> No  <input type="checkbox"/> Yes</p>	<p>2.21 您是否在担心未来几周内这些药品会被用完?</p> <p><input type="checkbox"/> 否  <input type="checkbox"/> 是</p>								
<p>2.22 Does your child take any medicines that have not been prescribed by a health professional e.g medicines you have bought at a pharmacy/shop/on the internet or had delivered from overseas?</p> <p><input type="checkbox"/> No  <input type="checkbox"/> Yes –<i>please list medicines and doses in the box below</i></p> <p><b>Please bring any medicines to your child’s appointment</b></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 70%;">Name</th> <th style="width: 30%;">Dose</th> </tr> </thead> <tbody> <tr> <td style="height: 150px;"></td> <td></td> </tr> </tbody> </table>	Name	Dose			<p>2.22 您的子女是否在服用一些没有经过专业医师开处方的药物? 例如, 您在药店, 商店, 网上购买, 或从国外运输至国内的药物。</p> <p><input type="checkbox"/> 否  <input type="checkbox"/> 是——<i>请在下方框中列出您的此类药物</i></p> <p><i>请将任意此类药物携带至您子女的预约地点</i></p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 70%;">姓名</th> <th style="width: 30%;">剂量</th> </tr> </thead> <tbody> <tr> <td style="height: 150px;"></td> <td></td> </tr> </tbody> </table>	姓名	剂量		
Name	Dose								
姓名	剂量								

<p>2.23 Does your child have allergy to any medicines?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>		<p>2.23 您的子女是否对某些药物过敏?</p> <p><input type="checkbox"/> 否</p> <p><input type="checkbox"/> 是</p>	
<p>2.24 Does your child have allergy to anything else? (e.g. food, insect stings, latex gloves)?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p>		<p>2.24 您的子女是否对任何其他事物过敏? (例如: 食物, 虫类叮咬, 乳胶手套)</p> <p><input type="checkbox"/> 否</p> <p><input type="checkbox"/> 是</p>	
<p>Section three: Vaccinations</p>		<p>第三部分 : 疫苗</p>	
<p>3.1 Has your child had all the childhood vaccinations offered in their country of origin for their age?</p> <p><b><i>If you have a record of your vaccination history, please bring this to your appointment.</i></b></p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> I don't know</p>		<p>3.1 您的子女是否在其所在国接种了所有儿童疫苗?</p> <p><b><i>如果您有疫苗接种记录, 请将其带至预约地。</i></b></p> <p><input type="checkbox"/> 否</p> <p><input type="checkbox"/> 是</p> <p><input type="checkbox"/> 不知道</p>	
<p>3.2 Has your child been vaccinated against Tuberculosis (TB)?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> I don't know</p>		<p>3.2 您的子女是否接种了肺结核疫苗?</p> <p><input type="checkbox"/> 否</p> <p><input type="checkbox"/> 是</p> <p><input type="checkbox"/> 不知道</p>	
<p>3.3 Has your child been vaccinated against COVID-19?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> 1 dose</p> <p><input type="checkbox"/> 2 doses</p>		<p>3.3 您的子女是否接种了新冠肺炎疫苗?</p> <p><input type="checkbox"/> 否</p> <p><input type="checkbox"/> 是</p> <p><input type="checkbox"/> 一针</p> <p><input type="checkbox"/> 两针</p>	

<input type="checkbox"/> 3 doses <input type="checkbox"/> More than 3 doses <input type="checkbox"/> I don't know	<input type="checkbox"/> 三针 <input type="checkbox"/> 三针以上 <input type="checkbox"/> 不知道
<p>If there is something relating to your child's health that you do not feel comfortable sharing in this form and you would like to discuss it with a doctor, please call your GP and book an appointment</p>	<p>如果您感到你的子女在健康方面存在问题且愿意在此表格中分享或与医生讨论，请致电您的全科医生并预约</p>