Date Form Completed:	

In order to be fully registered with this practice, this form MUST be completed by the parent/guardian

NEW PATIENT HEALTH QUESTIONNAIRE (FOR CHILDREN UP TO 16Y)

TITLE:		**FIRST NAME:**	
SURNAME:	**CURRENT SURNAME:**		
	PREVIOUS SURNAMES:		
DATE OF BIRTH:		**GENDER:**	**M F** (please tick)

ADDRESS :	**WHO ELSE LIVES IN THIS HOUSEHOLD?**(please tick all those that apply)
Postcode:	Mum Dad Step parent Parent's partner Grandparents Brothers and sisters how many? Foster carer guardian Others- please state

HOME TEL:		**MOBILE TEL:**	
EMAIL ADDRESS:			

WHO DO THESE DETAILS BELONG TO? **(e.g. mum, dad etc.)**	**EMAIL:**	
	HOME:	
	MOBILE:	
CAN WE LEAVE MESSAGES REGARDING YOUR CHILD ON THESE NUMBERS?	**MOBILE:**	**YES NO** (please tick)
	HOME:	**YES NO** (please tick)
Would you like to register with the Practice for SMS text messaging (This will include appointment reminders, some test results and any other useful information)?		**YES NO** (please tick)

WHO HAS PARENTAL RESPONSIBILITY FOR THIS CHILD? Please tell us their name, contact details (if not given above) **and their relationship to the child**

PREVIOUS ADDRESS:	PREVIOUS GP's NAME & ADDRESS:

HEALTH HISTORY

HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES OR OPERATIONS?	YES NO (please tick)
If Yes, what was this and when? :	
DOES YOUR CHILD HAVE A DISABLITY OR CHRONIC CONDITION?	**YES NO** (please tick)

MEDICATION

IS YOUR CHILD ON ANY REGULAR MEDICATION?	YES NO (please tick)
If Yes, please tell us the name and dose: (if you have a list from your previous GP please give us a copy) (Please note you may be need to see the doctor for a first repeat prescription to be issued)	
IS YOUR CHILD ALLERGIC TO ANY MEDICATION?	**YES NO** (please tick)
If Yes, please state type and name:	

Which school or nursery does your child attend?

Does your child have contact with any of the following? *(if so please can you tell us their names)*	
A hospital specialist? **YES** **NO** (please tick) A health visitor? **YES** **NO** (please tick) A social worker? **YES** **NO** (please tick) Any other health professionals? **YES** **NO** (please tick)	
Has your child ever been under a Child Protection Plan?	**YES** **NO** (please tick)

It is important that your child's immunisations are kept up to date. A current photocopy of the immunisation history will help us to maintain their immunisation record; we can take a photocopy of this at reception. If this is not available then please list below.

IMMUNISATIONS		**DATE GIVEN**
1st Diphtheria, Tetanus, Whooping Cough, Polio, Hib , *rotavirus**	*age 2m*	
2nd Diphtheria, Tetanus, Whooping Cough, Polio, Hib, *rotavirus**	*age 3m*	
3rd Diphtheria, Tetanus, Whooping Cough, Polio, Hib	*age 4m*	
1st Pneumococcal	*age 2m*	
2nd Pneumococcal	*age 4m*	
1st Meningitis C	*age 3m*	
Hib/ Meningitis C 1st Measles, Mumps, Rubella (MMR) Booster Pneumococcal	*age 12-13m*	
Booster Diphtheria, Tetanus, Whooping Cough, Polio Booster Measles, Mumps, Rubella (MMR)	*age 3y 4m*	
Details of any other immunisations:		

** rotavirus included since 2012*

IMPORTANT:

All the information given to the Practice as part of this form will be treated as Confidential.
However to give your child the very best health care we work closely with the Health Visiting and School Nursing Service.
It is therefore our normal Practice to share the details of all children registering with the Practice with our NHS colleagues in Health Visiting and School Nursing.
If you would prefer that we DO NOT do this could you tick here

WHAT IS YOUR ETHNIC GROUP?

Choose **ONE** section from A to F then tick **ONE** box which **best describes** your ethnic group or background

A. White	
British	
Irish	
Polish	
Any other white ethnic group, please specify below:	

B. Mixed or multiple ethnic groups	
Any mixed or multiple ethnic group	

C. Asian, Asian British	
Pakistani, or Pakistani British	
Indian, Indian British	
Bangladeshi, Bangladeshi British	
Chinese, Chinese British	
Other Asian, please specify:	

D. African	
African, African British	
Other African, please specify:	

E. Caribbean or Black	
Caribbean, Caribbean British	
Black, Black British	
Other Caribbean or Black, please specify:	

Other, please specify:

If you would prefer not to provide this information, please tick here:	

ETHNICITY & LANGUAGE QUESTIONNAIRE

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity, to support your health care.

NAME _____ **DOB** _____

What is your main language? | |

Do you need an interpreter or sign language support? **Yes** **No**

We would be grateful if you could complete **one form for each family member** within/joining the

FOR OFFCE USE:

Reg details to computer	
NHS no	
Scanned	
Sent to H/V S/N service	