|  |  |
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| **Date Form Completed:** |  |

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

|  |  |  |  |  |  |  |  |  |  |  |
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| **NEW PATIENT HEALTH QUESTIONNAIRE**  **(FOR CHILDREN UP TO 16Y)** | | | | | | | | | | |
| **TITLE:** |  | | **FIRST NAME:** | |  | | | | | |
| **SURNAME:** | | CU**RRENT 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)  **PLEASE NOMINATE A LOCAL CHEMIST:** | |
| **IS YOUR CHILD ALLERGIC TO ANY MEDICATION?** | **YES**  **NO**  (please tick) |
| **If Yes, please state type and name:** | |

|  |  |
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| **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) *age 12-13m*  Booster Pneumococcal |  |
| Booster Diphtheria, Tetanus, Whooping Cough, Polio *age 3y 4m*  Booster Measles, Mumps, Rubella (MMR) |  |
| 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** | | |  | **B. Mixed or multiple ethnic groups** | | |
| British |  | | Any mixed or multiple ethnic group |  | |
| Irish |  | |  |  | |
| Polish |  | | **D. African** | | |
| **Any other white ethnic group, please specify below:** | | | African, African British |  | |
|  | | | **Other African, please specify:** | | |
|  | | |  | | |
| **C. Asian, Asian British** | | |  | | |
| Pakistani, or Pakistani British | |  | **E. Caribbean or Black** | | |
| Indian, Indian British | |  | Caribbean, Caribbean British |  | |
| Bangladeshi, Bangladeshi British | |  | Black, Black British |  | |
| Chinese, Chinese British | |  | **Other Caribbean or Black, please specify:** | | |
| **Other Asian, 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 |  |