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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) |
|  |

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| **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.**

|  |  |
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| **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 C1st 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** [ ]

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| **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  |  |