QUEEN SQUARE MEDICAL PRACTICE – NEW PATIENT QUESTIONNAIRE FOR CHILDREN UNDER SIXTEEN (Except Newborn babies)

PRIVATE & CONFIDENTIAL

Child's Full Name

_____

Previous Name (if applicable)

_____

Date of Birth ___/___/___

Home tel: _____

Present Address

_____

_____

Post Code _____

Who has Parental Responsibility:_____

Telephone No (if diff. to home tel)_____

Tick if you wish to "Opt-out" and withhold your child's Clinical information from the SCR (Summary Care Record) □

Tick if you do not wish to receive SMS reminders: □

Ethnic Origin

We are obliged to inform the NHS of your ethnic origin. If, however, you do not wish to disclose this information, please tick the last option.

White – British	
White - Irish	
White - other background	
Black or Black British-Caribbean	
Black or Black British-African	
Other Black background	
Asian or Asian British-Indian	
Asian or Asian British-Pakistani	
Asian or Asian British-Bangladeshi	
Chinese or other ethnic Background-Chinese	
Other Asian background	
Mixed-White & Black Caribbean	
Mixed-White & Black African	
Mixed-White & Asian	
Other Mixed Background	
Other Ethnic background	
I do not wish to disclose my ethnic origin	

Previous Address (If applicable)

_____

_____

Mother's Name _____

Mother's Date of Birth _ _ / _ _ / _ _

Mother's Address (If different from child)

_____

_____

Father's Name _____

Father's Date of Birth _ _ / _ _ / _ _

Father's Address (if different from child)

_____

_____

Child's Primary Carer: _____

Present School (if applicable)

_____

Previous School (if applicable)

_____

Previous School Nurse (if applicable)

_____

Previous Health Visitor (if applicable)

_____

Previous General Practitioner (if applicable)

_____

_____

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Past Medical History:

1. _____ Date __/__/___
2. _____ Date __/__/___
3. _____ Date __/__/___

Medicines/Tablets/Regular Prescriptions:

(Please arrange appointment with GP to obtain medication)

1. _____
2. _____
3. _____
4. _____

Family History –

Diseases that can run in the family:
(*Has anyone in your family ever had?*
Please state)

Heart Disease _____ Age ____
High Blood Pressure_____
Stroke_____
Diabetes_____
Eye Disease _____
Asthma _____
Cancer _____
Thyroid disease _____
Epilepsy/fits_____
Other _____

	Age	State of health: Well/unwell	If deceased, cause & age
Mother			
Father			
Brothers / Sisters			

ALLERGIES:

Are you allergic to any medicines YES/NO

Which ones? _____

Any other allergies?_____

Developmental Checks:
(Please circle checks carried out)
6 weeks/ 9 months/ 39 months

IMMUNISATIONS

IMMUNISATION	DATE	IMMUNISATION	DATE
1st DTP/ Polio/ Hib		1st Men B	
2nd DTP/ Polio/ Hib		2nd Men B	
3rd DTP/ Polio/ Hib		3rd Men B	
1st PCV		2nd PCV	
Menitorix (Hib/Men C)		MMR	
3rd PCV		Men C	
Preschool (DTP/IPV)/		2nd MMR	
Hep B			
Other: (please give details)			

Were these given at GP practice
Y/N/Overseas

Is it possible for us to take a copy of child's red book?
YES/NO If so, please bring along with this form

DIET

Does their diet normally include?

Daily fruit & veg Yes/No
Snacks & fast foods Yes/No
Regular fries/chips Yes/No
Restrictions (specify) _____

Is there anything else you feel we should know about your child's health?

_____
_____

Thank you for completing this questionnaire.
Please sign and date below.

Signature……

Relationship to Child ……
Date……..……..

Office Use Only
Reception Staff to Complete:-
Date Received:…… Staff Initials:…..…..…..… Confirm Parent/Guardian registered at same address Yes/No
Admin Staff to Complete:-
Date Info entered on EMIS:…… EMIS No:…… Registered Dr:…….. Staff Initials:…..……
Imms for Coding YES/NO SCR: YES/NO SMS: YES/NO