

Date Form Completed:	
----------------------	--

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

<b>NEW PATIENT HEALTH QUESTIONNAIRE (FOR CHILDREN UP TO 16Y)</b>			
<b>TITLE:</b>		<b>FIRST NAME:</b>	
<b>SURNAME:</b>	<b>CURRENT SURNAME:</b>		
	<b>PREVIOUS SURNAMES:</b>		
<b>DATE OF BIRTH:</b>		<b>GENDER:</b>	M <input type="checkbox"/> F <input type="checkbox"/> (please tick)
<b>ADDRESS :</b>		<b>WHO ELSE LIVES IN THIS HOUSEHOLD?</b> (please tick all those that apply)	
		Mum <input type="checkbox"/> Dad <input type="checkbox"/> Step parent <input type="checkbox"/> Parent's partner <input type="checkbox"/> Grandparents <input type="checkbox"/> Brothers and sisters <input type="checkbox"/> how many? <input type="checkbox"/> Foster carer <input type="checkbox"/> guardian <input type="checkbox"/> Others- please state	
<b>Postcode:</b>			
<b>HOME TEL:</b>		<b>MOBILE TEL:</b>	
<b>EMAIL ADDRESS:</b>			
<b>WHO DO THESE DETAILS BELONG TO?</b> (e.g. mum, dad etc.)		<b>EMAIL:</b>	
		<b>HOME:</b>	
		<b>MOBILE:</b>	
<b>CAN WE LEAVE MESSAGES REGARDING YOUR CHILD ON THESE NUMBERS?</b>		<b>MOBILE:</b>	YES <input type="checkbox"/> NO <input type="checkbox"/> (please tick)
		<b>HOME:</b>	YES <input type="checkbox"/> NO <input type="checkbox"/> (please tick)
<b>Would you like to register with the Practice for SMS text message reminders?</b>		YES <input type="checkbox"/> NO <input type="checkbox"/> (please tick)	
<b>WHO HAS PARENTAL RESPONSIBILITY FOR THIS CHILD? Please tell us their name, contact details (if not given above) and their relationship to the child</b>			
<b>PREVIOUS ADDRESS:</b>		<b>PREVIOUS GP's NAME &amp; ADDRESS:</b>	
<b>HEALTH HISTORY</b>			

<b>HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES OR OPERATIONS?</b>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> (please tick)
If Yes, what was this and when? :	
<b>DOES YOUR CHILD HAVE A DISABILITY OR CHRONIC CONDITION?</b>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> (please tick)

<b>MEDICATION</b>	
<b>IS YOUR CHILD ON ANY REGULAR MEDICATION?</b>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> (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)	
<b>IS YOUR CHILD ALLERGIC TO ANY MEDICATION?</b>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> (please tick)
If Yes, please state type and name:	

<b>Which school or nursery does your child attend?</b>	
<b>Does your child have contact with any of the following? (if so please can you tell us their names)</b>	
A hospital specialist? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> (please tick) A health visitor? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> (please tick) A social worker? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> (please tick) Any other health professionals? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> (please tick)	
<b>Has your child ever been under a Child Protection Plan?</b>	<b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/> (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.**

<b>IMMUNISATIONS</b>	<b>DATE GIVEN</b>
1 <sup>st</sup> Diphtheria, Tetanus, Whooping Cough, Polio, Hib , <i>rotavirus</i> * <i>age 2m</i>	
2 <sup>nd</sup> Diphtheria, Tetanus, Whooping Cough, Polio, Hib , <i>rotavirus</i> * <i>age 3m</i>	
3 <sup>rd</sup> Diphtheria, Tetanus, Whooping Cough, Polio, Hib <i>age 4m</i>	
1 <sup>st</sup> Pneumococcal <i>age 2m</i>	
2 <sup>nd</sup> Pneumococcal <i>age 4m</i>	
1 <sup>st</sup> Meningitis C <i>age 3m</i>	
Hib/ Meningitis C	
1 <sup>st</sup> Measles, Mumps, Rubella (MMR) <i>age 12-13m</i>	
Booster Pneumococcal	
Booster Diphtheria, Tetanus, Whooping Cough, Polio <i>age 3y 4m</i>	
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**

# 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.

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

**NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_

What is your main language?

--

Do you need an interpreter or sign language support?

Yes

No

## 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	<input type="checkbox"/>
Irish	<input type="checkbox"/>
Polish	<input type="checkbox"/>
Any other white ethnic group, please specify below:	

C. Asian, Asian British	
Pakistani, or Pakistani British	<input type="checkbox"/>
Indian, Indian British	<input type="checkbox"/>
Bangladeshi, Bangladeshi British	<input type="checkbox"/>
Chinese, Chinese British	<input type="checkbox"/>
Other Asian, please specify:	

If you would prefer not to provide this information, please tick here:	<input type="checkbox"/>
--	--------------------------

B. Mixed or multiple ethnic groups	
Any mixed or multiple ethnic group	<input type="checkbox"/>

D. African	
African, African British	<input type="checkbox"/>
Other African, please specify:	

E. Caribbean or Black	
Caribbean, Caribbean British	<input type="checkbox"/>
Black, Black British	<input type="checkbox"/>
Other Caribbean or Black, please specify:	

Other, please specify:	

### FOR OFFICE USE:

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