EAST BARNWELL HEALTH CENTRE

NEW PATIENT QUESTIONNAIRE- FOR CHILDREN AGED 0-16 YEARS

PERSONAL DETAILS	
Title (Please circle as appropriate): Mr / Miss / Other	
First Name(s):	**Date of Birth:**
Surname:	**Sex:**
Previous Surname(s):	

CONTACT DETAILS	
Home Address:	**Home Tel:**
	Mobile Tel:
Email:	**Who do these contact details belong to? Please state** **……** ***Please provide two contacts if parents living separately.***
I consent to the practice contacting me on occasion by text/email for the purpose of health promotions and for appointment reminders: YES / NO	
Next of Kin:	**Relationship:**
Next of Kin Contact Details:	
What School/Nursey does your child attend?	**……**
Does your child have any contact with any of the following?	
A Hospital Specialist	**YES / NO**
A Health Visitor	**YES / NO**
A Social Worker	**YES / NO**
Any other health professional?	**Please state:**
Has your child ever been under a Child Protection Plan? YES / NO	**YES / NO**

PREVIOUS GP	
Name of previous GP Practice:	**Telephone:**
Address:	

ETHNICITY, RELIGION & LANGUAGE	
Ethnic Origin (please circle as appropriate):	
White	British /Irish / Other
Mixed	White & Black Caribbean / White & Black African / White & Asian / Other
Asian or Asian British	Indian / Pakistani / Bangladeshi /Chinese / Other
Black or Black British	Caribbean / African / Other
Other, please state:	
Religion:	
First Language:	
	Do you need an interpreter for your appointments? YES / NO

PRE-EXISTING MEDICAL CONDITIONS	
Does your child have a disability or chronic condition? YES / NO	If yes, please state:
Has your child had any serious illnesses or operations? YES / NO	If yes, please state:

MEDICATIONS	
Please list any medications your child regularly takes : **If you have a list of repeat medication, please hand this in at reception.**	
Nominated Pharmacy: **Which pharmacy would you like to collect your prescriptions from?**	
If you have medication on repeat, please make an appointment to speak with a GP before your next prescription is due. If you take the oral contraceptive pill, please book appointment for a pill check with the Practice Nurse.	

ALLERGIES	
Does your child have any allergies? **(including allergies to medication)** YES / NO	**If yes, please state:**

PERSONAL HEALTH		
Height:		**Weight:**
Does your child smoke? Current Smoker / Ex-smoker / Never Smoked / Exposed to smoke at home		
For Current/Ex-smokers:	**How many cigarettes per day?**	
	How old were you when you started?	
	Approximate age when stopped:	
If you would like help to give up smoking please enquire at reception for details of our smoking cessation services.		
Do you exercise regularly?	YES / NO If yes, approximately how many hours per week? ……	

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:	

SUMMARY CARE RECORD
Your summary care record will be used in an emergency. The record will contain information about any medicines you are taking, allergies you suffer from and any bad reactions to medicines you have had to ensure those caring for you have enough information to treat you safely. *If you do not want a summary care record, please ask at reception and complete the SCR Opt-out form.*

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 ☐

Signature of parent/guardian:	
Do you have Parental Responsibility?	YES/NO
Date:	

To be completed by receptionist:

Primary ID seen and signature verified: **(Passport / Driving License)**		**Secondary ID seen and address verified:** **(utility bill)**	
Registering GP: Dr……..	**Informed** **Yes / No**	**Smoking cessation**	**Informed** **Yes / No**

Questionnaire to be scanned into patient's medical record