NEW PATIENT REGISTRATION QUESTIONNAIRE - CHILD

Date _ _/ _ _ /_ _

To register your child with the Practice please complete this questionnaire as fully as possible before their new patient assessment and also bring in **two forms of identification** either passport or birth certificate. These must all be original documents and not copies. This has to be done prior to being registered.

Surname: …….. Forename(s): ……

Address: …….

……..… Postcode: ……

Date of Birth: ……Age in years:..……. Place of birth:……..… Home tel:

…… Mobile: ……Tick box to signify happy to receive text messages such as reminders: ☐

Email address: ……

Previous GP……

Name of Parents & contact details: Mother……
Father……

School Attended……..

What Language is spoken at home? ……

What is your Religion? ……..

Ethnicity – please tick appropriate box (one box only)

British or British Mixed ☐ Irish ☐ Other White Background ☐ White and Black Caribbean ☐

White and Black African ☐ White and Asian ☐ Other Mixed Background ☐ Indian or British Indian ☐

Pakistani or British Pakistani ☐ Bangladeshi or British Bangladeshi ☐ Other Asian background ☐

Caribbean ☐ African ☐ Other Black Background ☐ Chinese ☐

Ethnic category not stated ☐ Any other Ethnic Group ☐

SMOKING

Does anyone at home smoke: Yes / Not Any Longer / Never

If Yes, do they want help in giving up…….

Weight (approx): **…….. Height**: ……

DIET

Do you have a varied diet at home including milk, meat, vegetables and fruit? Yes / No

PAST/PRESENT MEDICAL CONDITIONS
Please give details (& dates) of any illnesses including hospital treatments & operations:
……
……..

Do they have any special needs ?……

MEDICATION
Please give details of any medication which you take (prescribed or otherwise):
Please bring your repeat request form or the containers to your first appt

Name of drugs & Dosage: ……
……
……
……

ALLERGIES
Are they allergic to any substances or foods? Yes / No

If yes, please give details:
……
……

IMMUNISATIONS. These are important in order to protect against illnesses which can only be prevented by developing your child's natural immunity.

Please give details immunisations & dates which your child has had so far – including holiday jabs:
List here (Nurse will confirm) e.g.

Primary Course: Diphtheria /Tetanus/Pertussis /Polio /HIB/Pneumococcal/Rotavirus at 2mths ……
Diphtheria/Tetanus/Pertussis/Polio/HIB/MenC/Rotavirus at 3mnths……..
Diphtheria/Tetanus/Pertussis/Polio/HIB/Pneumococcal at 4mnths……
HIB/MenC/Pneumococcal/MMR between 12&13 mnths ……
Influenza 2,3&4 yrs ……..
Pre-school Booster Diphtheria /Tetanus/Pertussis /Polio /MMR……
13yrs Rubella /Giardasil ……..
Final School boosters Tetanus /Diphtheria/Polio /MenC……
Other Immunisations ……..
……

FAMILY HISTORY
Is there any of the following in their close family *(parents, grandparents, brother, sister)* before age of 65? Heart Disease (heart attacks, angina) / Stroke / Insulin dependant diabetes / Glaucoma or Cancer (specify site) or Any other known hereditary disease ?

Condition(s) & family member(s) affected? ……
……
……

Have you any concerns about your child's health that you would like to discuss with the Doctor or Health Visitor ? .....
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PLEASE ASK AT RECEPTION DESK FOR DETAILS OF HEALTH VISITOR CLINICS ETC