

NEW PATIENT QUESTIONNAIRE (CHILDREN UNDER 16)

Within a month of registering we would like you to make an appointment with the Practice Nurse or Health Care Assistant to discuss the general health and immunisation status of your child. Please complete as many questions as you can and bring along a **urine specimen** from your child to the appointment.

THANK YOU

Date:	Place of birth:	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Surname:	First Name:	Date of Birth:	Age:

Full Address:

Telephone Numbers: HOME: MOBILE:	School or Nursery Attended:
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Ethnicity					First Language
White	Asian	Black/Black British	Other		
British <input type="checkbox"/>	Indian <input type="checkbox"/>	Caribbean <input type="checkbox"/>	Chinese <input type="checkbox"/>		
Irish <input type="checkbox"/>	Pakistan <input type="checkbox"/>	African <input type="checkbox"/>	Other Ethnic <input type="checkbox"/>		
Other <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Other <input type="checkbox"/>	Not stated		
	Other <input type="checkbox"/>		Prefer not to state <input type="checkbox"/>		

PAST MEDICAL HISTORY

Please list with approximate dates any serious previous illnesses, long-term illnesses, disabilities or major operations:

FAMILY HISTORY

Please indicate if your child's close relatives i.e. parents, grandparents, brothers and sisters have suffered from any of the following:

Asthma <input type="checkbox"/>	Cancer <input type="checkbox"/>	Diabetes <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>
Epilepsy <input type="checkbox"/>	Glaucoma <input type="checkbox"/>	Heart Attack <input type="checkbox"/>	Stroke <input type="checkbox"/>
High Cholesterol <input type="checkbox"/>	Thyroid Disease <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>	

IMMUNISATION STATUS

Please indicate whether immunisations were given at GP Surgery, Clinic or School and give approximate dates. Please bring your child's personal health record, or **Red Book** to the appointment. Please delete, where appropriate, if any immunisation was NOT given.

AGE	IMMUNISATIONS	DATE	WHERE GIVEN
2 months	1st Diphtheria/Tetanus/Pertussis/Polio/Hib/Pneumococcal		
3 months	2nd Diphtheria/Tetanus/Pertussis/Polio/Hib/Meningitis C		
4 months	3rd Diphtheria/Tetanus/Pertussis/Polio/Hib/Pneumococcal/Meningitis C		
12 months	Hib booster/Meningitis C		
13 months	Measles/Mumps/Rubella (MMR), Pneumococcal		
3-5 years	Diphtheria/Tetanus/Pertussis/Polio/MMR (Pre-school boosters)		
13-18 years	Tetanus/Diphtheria/Polio		

Is your child allergic to any medication or anything else?					
Do they have heart problems?	Yes	No	Are they Diabetic?	Yes	No
Do they have Asthma?	Yes	No	Are they a Named Carer?	Yes	No
Are they Disabled?	Yes	No	Do they have a Named Carer?	Yes	No
Do they have a special Diet?	Yes	No			
Are they currently under the care of a hospital? If so please indicate which hospital and give brief details					
If your child is taking any regular medication please attach their up-to-date repeat prescription form from your previous surgery - if this is not available you will need to book an appointment for a medication review with a Doctor or Nurse Practitioner					
Approximate Height			Approximate Weight		
SURGERY USE ONLY					
Confirmation of address seen?	Yes	No	Urine specimen bottle provided	Yes	No
Date of new patient check	/	/	Time	am/pm	