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** ☐	**Female** ☐

Surname:	**First Name:**	**Date of Birth:**	**Age:**

Full Adress:

Telephone Numbers: **HOME:** **MOBILE:**	**School or Nursery Attended:**

Ethnicity

White	**Asian**	**Black/Black British**	**Other**	**First Language**
British ☐	Indian ☐	Caribbean ☐	Chinese ☐	
Irish ☐	Pakistan ☐	African ☐	Other Ethnic ☐	
Other ☐	Bangladeshi ☐	Other ☐	**Not stated**	
	Other ☐		Prefer not to state ☐	

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 ☐	Cancer ☐	Diabetes ☐	High Blood Pressure ☐
Epilepsy ☐	Glaucoma ☐	Heart Attack ☐	Stroke ☐
High Cholesterol ☐	Thyroid Disease ☐	Tuberculosis ☐	

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**	