Glemsford Surgery
Child NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

Welcome to our Surgery

To the Patient's Parent/Carer:

To register with the practice, please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your health which will help in your future treatment. Patients will be asked to attend the practice for an initial consultation and some basic checks.

Surname: ……..… Forename(s): ……..…… Date of Birth: ……

Address:
……..……
……

……..…… Postcode:
...……..……

Home tel: ……..……..……..…… Mobile:
……...……..…..…

Email address:
……
……

Weight (approx): ……..……..…….. Height:
……..……..……..…

Sex: Male / Female

Who has parental responsibility for the Child?
Name(s):……
……..
Address:……
……...
Telephone number: ……...
Mobile:……...

Is the Child a Looked After Child or have they been? *YES/NO*
Does the Child have a Social Worker? *YES/NO* *If yes, name is……*
Is the Child subject to a Supervised Guardianship Order? *YES/NO* *If yes, please provide documents*

Please tick the box on the right if you agree to be contacted via SMS text message with appointment reminders or other health related updates. ☐

Date of completion of this form: ……

Ethnic Origin

Please indicate the patient's ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

A White

	British
	Irish
	Any other white background, please state:

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background, please state:

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background, please state:

D Black or Black British

	Caribbean
	African
	Any other black background, please state:

E Chinese or other ethnic group

	Chinese
	Any other, please state:

First language: ☐

Smoking – <u>Children aged 14 and over only</u>

Do you smoke? *Yes* / *No*

If *Yes*, how many…: Cigarettes per day …….. Ounces of tobacco per day ……..

How old were you when you started smoking? ……

Passive Smoking – <u>all children</u>

Is the child exposed to passive smoke? *Yes* / *No* At home? *Yes* / *No*

Family History

Is there any of the following in the patient's family *(father, mother, brother, sister)* before the age of 65?

Heart Disease (e.g. heart attacks, angina) *Yes* / *No* which family member?
…….

Stroke *Yes* / *No* which family member?
…….

Cancer *Yes* / *No* which family member?
…….
Site of cancer?
……
Asthma *Yes* / *No* which family member?
…….

Other…. *Yes* / *No* which family member?
…….

Does the Child have a diagnosed disability? Yes/No If yes, please state
……..

Safeguarding

Are there any safeguarding concerns or issues relating to this child?

Medication

Please give details of any medication taken (prescribed or otherwise):

Name of drug: ……

Dosage: …….

Name of drug: ……

Dosage: …….

Name of drug: ……

Dosage: …….

- If your child has regular prescribed medicine, you will need an appointment to see a GP. It may be useful to bring in a copy of your child's prescription list from your previous surgery.
- Which pharmacy would you prefer to collect medication from?

Glemsford	YES/NO
Other – please state	YES/NO

- Are you happy for your Dr to sign your scripts electronically and send them to your nominated pharmacy digitally? YES/NO

Allergies

Is the patient allergic to any substances, including medication or foods? *Yes* / *No*

If *Yes*, please give details:

……

……

……

……

Past Medical History

Please give details of any hospital treatment as an in-patient:

……

……

Please give details of any treatment for any chronic medical conditions:

……

……

Please give dates of any X-ray/MRI or CT scans/mammogram/ultrasound:

……

……

Childhood Immunisations

Dates of triple/polio/HIB:

……..

Dates of MMR:

……..……..

Pre-school booster(s):

…….

General

Are there any other issues which cause you concern or would you like advice on any other health problems? Please give details below or ask a Receptionist to make an appointment with a clinician if you wish to discuss anything privately.

Thank you for completing this questionnaire. Our clinical team will assess the information provided and will invite you for an initial examination, discussion about your health, and general check within the next few days.