New Patient Health Questionnaire for Children

Your Child's Details

Title _____ Surname _____

Date of Birth _____ First Name _____

Home Address _____

_____

_____

_____

_____

Postcode _____

Parent or Guardian Contact Details

Name _____

Home Tel _____

Work Tel _____

Mobile _____

Email _____

Please provide an email address where possible

Information About Your Child

What is your child's height? _____ What is your child's weight? _____

What is your child's first language? _____

Does your child have a sight/hearing impairment or NEED information in a different format? ☐ Yes ☐ No

What is your child's ethnic group?

White	☐ British	☐ Irish	☐ Other	*If other please specify* _____
Black	☐ Caribbean	☐ African	☐ Other	*If other please specify* _____
Asian	☐ Indian	☐ Pakistani	☐ Chinese ☐ Other	*If other please specify* _____
Mixed	☐ White + Black African ☐ White + Asian		☐ White + Black Caribbean ☐ Other	*If other please specify* _____

Previous GP

Name and Address of Previous GP _____

_____

_____

_____

Medical Information

Please list any serious illness/operations/accidents/disabilities and the year they took place

_____

_____

Has your child ever suffered from ? (tick as appropriate)

Epilepsy	☐ Yes	☐ No		Diabetes	☐ Yes	☐ No	
Eczema/Hay Fever	☐ Yes	☐ No		Asthma	☐ Yes	☐ No	

If yes to any of the above, please state the year of diagnosis.

_____

Please list any medicines being taken and the amount:

_____

_____

Medical Information continued:

Is your child registered disabled? (If yes please give details) ☐ Yes ☐ No

Is your child allergic to any medicines and if so, which? ☐ Yes ☐ No

Family History

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes or any inherited disease. Please state the relationship of the child to the individual.

Next of Kin: Please give name, address and telephone number of your child's next of kin

Name: _____

Address: _____

Telephone Number: _____

Relationship to child: _____

Vaccinations

			Approximate Date
Diptheria / Tetanus / Whooping Cough	☐ Yes	☐ No	_____
Polio	☐ Yes	☐ No	_____
Hib	☐ Yes	☐ No	_____
Measles / Mumps / Rubella (MMR)	☐ Yes	☐ No	_____
Meningitis C	☐ Yes	☐ No	_____

Please list any other vaccinations that your child has had or ask reception to copy their Red Book.

I agree that I may be contacted from time to time, via email and/or SMS, with Practice news, health advice and/or appointment reminders for my child. ☐ Yes ☐ No

I confirm that the information I have given in this New Patient Questionnaire is correct.

Signature of Parent or Guardian _____ **Date** _____
(you will be asked to sign this form when you visit the Practice)

FOR OFFICE USE ONLY

Forms & Questionnaire checked? ☐ Yes ☐ No

Has patient been informed of Named GP? ☐ Yes ☐ No

Who is the named GP? _____

Name & signature of staff member: _____