NEW PATIENT QUESTIONAIRE FOR PATIENTS

UNDER 16 YEARS

Welcome the Amersham Vale Practice

We would like your Parents/Carers to complete this form.

It is of enormous benefit to the Doctors and Nurses to know something about your child’s medical background when you visit the surgery since we may not have receive your child’s notes from your previous surgery for some time.

**Today’s Date:**

**Child’s Full Name:**

**Child’s Date of Birth:**

**Child’s Gender: Male Female Other**

**Name of Parent or Carer:**

**Relationship to Child:**

**Parent/Carer’s Contact Mobile Number:**

**Parent/Carer’s Email Address:**

I am happy for the Practice to contact me via email: Yes No

I am happy for the Practice to communicate with me via Text (SMS): Yes No

**THIS SECTION MUST BE COMPLETED**

**What School or Nursery Does your Child Attend:**

**Name of School/Nursery:**

**Address of School:**

Child’s Main Language Spoken:

Parent’s Main Language Spoken:

Interpreter Required? Yes No

Ethnic Group *(Optional):* Please select the one that you think best applies to you, this helps us to monitor that we are reaching all sections of the community:

A - British/Mixed

B - Irish

C - Other white

D - Mixed W&B Caribbean

E - Mixed W&B African

F - Mixed white & Asian

G - Other Mixed

H - Indian

I - Pakistani

J - Bangladeshi

K - Other Asian

L - Caribbean

M - African

N - Other Black

O - Chinese

P - Any other Ethnic group (please specify)

**Smoking:**

Does anyone in the household smoke? Yes No

Does the (child over 13 years old) smoke? Please select:

A - Never Smoked

B - Ex-Smoker. Please note the date you stopped smoking:

C - Current Smoker.

If you smoke **cigarettes** how many smoke per day:

If you smoke **Roll ups tobacco** how many smoke per week:

If you smoke **Anything Else** please mentioned if and how often you smoke them:

Social Services:

**Does the child/family have any contact with a social worker? If yes, please give details of social worker if known:**

Yes No

**Please give further details:**

Your Child’s Medical History

Please indicate if your Child has a personal history or family history of any of the following medical conditions.

Your Child (Please include year of diagnosis if you know)

Your close family (please state if Maternal/Paternal relative and age of diagnosis, if known)

Heart disease:

Stroke:

High blood pressure:

Diabetes:

Asthma:

Epilepsy:

Cancer (please state type):

HIV:

Other Past Medical History:

Medication - Please list any regular medication that your child takes:

Allergies - Please list any allergies that your Child has:

Immunisations - Please arrange an appointment to see the Practice Nurse with your red book, so that we can update your records.

Person filling this form Name:

I filled in on behalf of the patient, relationship to patient:

Signed:

Date: