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/Carer |  | Relationship to Child |  |
|  |
| What School or Nursery Does your Child attend?(MUST BE COMPLETED) | Name of School/Nursery: | Address of School: |  |
|  |
| 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 ☐ |
|  |
| Child’s Main Language Spoken |  |
|  |
| Parent’s Main Language Spoken |  | Interpreter Required? | Yes ☐ No ☐ |
|  |
| Ethnic Group: (Optional) Please tick 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 ☐ F. Mixed white & Asian ☐ K. Other Asian ☐B. Irish ☐ G. Other Mixed ☐ L. Caribbean ☐C. Other white ☐ H. Indian ☐ M. African ☐D. Mixed W&B Caribbean ☐ I. Pakistani ☐ N. Other Black ☐E. Mixed W&B African ☐ J. Bangladeshi ☐ O. Chinese ☐Any other Ethnic group (please specify)……………………………………………………………………………………. |
| Smoking:Does anyone in the household smoke? Yes ☐ No ☐Does the (child over 13 years old) smoke? Never smoked ☐Ex-smoker ☐ Stopped on ………………………. Enter date………………………………………Current Smoker ☐ Cigarettes per day……………………. Roll ups tobacco per week…………………….. Other ……………………………………………………..  |
|  |
| 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 ☐ |
|  |
| Your Child’s Medical HistoryPlease 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. |
|  |
| Name …………………………………………………………………………………………………..I filled in on behalf of the patient, relationship to patient ………………………………………..Signed ………………………………………… Date …………………………………….. |

Return this form to LEWCCG.g85698-general@nhs.net with Subject – “Under 16 New Patient”