**WOODLAND ROAD SURGERY**

**NEW PATIENT FORM (CHILD)**

**PRIVATE AND CONFIDENTIAL**

**ALL SECTIONS MUST BE COMPLETED TO PROCESS YOUR REGISTRATION**

Please complete the questionnaire as full and accurately as possible so that we have important medical information to hand should you need to a clinician prior to the receipt of your medical records

Surname: ………………………………………… Forename(s): ………………………………………………….

Date of Birth: ……………………………… Previous Surname: ………………………………………………….

Address: ………………………………………………………………………………………………………………..

Previous Address: …………………………………………………………………………………………………….

Home Tel: ………………………… Mobile: ………………………… Work Tel: ………………………………….

Carer name and address (if child not living with parents): ………………………………………………………..

……………………………………………………………………………………………………………………..........

Tel: ………………………… Relationship if not parent: ……………………………………………………………

School attended: ……………………………… Previous School attended: ………………………………..........

**Carers** – a carer is someone who looks after a relative, friend or neighbor who has a long-term illness, disability, mental health problem or frailty due to old age and it is not a formal employment in carrying out their caring role.

Are you are carer? Yes No Do you have a carer? Yes No

*If yes please ask at reception for more information about support available to you as a carer*

**Current Health Status**

Height: …………………………… Weight: …………………………… Waist: ……………………………

Your current smoking status:

Never smoked Ex-smoker Current smoker (How many per day?) ……………

**If current smoker would you like to benefit from the advice we can offer you in quitting? YES / NO**

Do you have any special dietary requirements?

Normal Diet Vegetarian Weight Reducing Other: ……………………………………….

How much exercise do you take?

Exercise physically impossible I avoid all exercise I enjoy light exercise

I enjoy moderate exercise I enjoy heavy exercise I am a competitive athlete

Do you use contraception?

No Yes: (please specify) ……………………………………………………………………………….

**Personal History**

Are you taking any medication at present? YES / NO

If yes please give the following details or attach your previous medication list to this form.:

|  |  |  |
| --- | --- | --- |
| **Name of Medication** | **Strength** (e.g. mg) | **Dose** (i.e. how many timesper day) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Do you suffer with allergies? YES / NO

If yes please give details

|  |  |  |
| --- | --- | --- |
| **Allergy**  | **Reaction** (i.e. rash/collapse) | **Severity**(mild/ moderate / severe) |
|  |  |  |
|  |  |  |
|  |  |  |

Are you waiting for or receiving treatment from hospital?

No Yes (please specify) ……………………………………………………………………………………

Do you have difficulties with any of the following?

Mobility Vision Hearing Learning difficulties Other

If yes, please give details: ……………………………………………………………………………………………

……………………………………………………………………………………………………………………………

Occasionally the surgery may need to contact you or send out information. This is usually done by telephone or letter. The surgery is committed to communicating effectively with **all** patients. If you have any difficulties, please let us know if you would benefit from any of the following communication methods:

Braille Large Font Interpreter Services Text Message Services

Email services Other (please specify) ……………………………………………………………………….

………………………………………………………………………………………………………………………………

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **IMMUNISATIONS** | **Please🗸****If done** | **Date** | **Where given** (i.e. abroad/Drs Surgery in UK) |
| 2 months old | Polio |  |  |  |
| Diphtheria, Tetanus, Pertussis and HIB (DTP-HIB) |  |  |  |
| Men C |  |  |  |
| 3 months old | Polio |  |  |  |
| Diphtheria, Tetanus, Pertussis and HIB (DTP-HIB) |  |  |  |
| Men C |  |  |  |
| 4 months old | Polio |  |  |  |
| Diphtheria, Tetanus, Pertussis and HIB (DTP-HIB) |  |  |  |
| Men C |  |  |  |
| Around 13 months | Measles, Mumps and Rubella (MMR2) |  |  |  |
| 3-5 yearsPre-school | Polio |  |  |  |
| Diphtheria, Tetanus and Acellular, Pertussis (DtaP) |  |  |  |
| Measles, Mumps and Rubella (MMR2) |  |  |  |
| HIB Booster |  |  |  |
| 10-14 years | BCG (against tuberculosis – done at school |  |  |  |
| 15-18 years | Tetanus and low dose diphtheria (Td) |  |  |  |
| Polio |  |  |  |
| Other |  |  |  |  |

Do you suffer or have you ever suffered with any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| **Stroke / TIA** |  | **Lung disease** |  |
| **Hypertension** |  | **Diabetes** |  |
| **Hayfever** |  | **Glaucoma** |  |
| **Epilepsy** |  | **Schizophrenia** |  |
| **Rheumatoid arthritis** |  | **High cholesterol** |  |
| **Heart disease** |  | **Osteoporosis** |  |
| **Cancer** |  | **Depression** |  |
| **Eczema** |  | **Thyroid disease** |  |
| **Anxiety** |  | **Osteoarthritis** |  |
| **Drug addictions** |  | **Bipolar disorder** |  |
| **Asthma** (requiring inhalers in the last 12 months) |  | **Other *(please specify below)*** |  |

**Family Medical History**

Does anyone in your close family (i.e.mother, father, brother or sister) have any of the medical problems listed above? If so please state which ones

|  |  |
| --- | --- |
| **Relation** | **Condition**  |
| **Relation** | **Condition** |
| **Relation**  | **Condition** |
| **Relation** | **Condition** |

**PATIENT ETHNIC ORIGIN QUESTIONNAIRE**

*This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.*

Please indicate your 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.

D Black or Black British

|  |  |
| --- | --- |
|  | Caribbean |
|  | African |
|  | Any other mixed background please write below |

|  |
| --- |
|  |

A White

|  |  |
| --- | --- |
|  | British |
|  | Irish |
|  | Any other white background please write below |

|  |
| --- |
|  |

B Mixed

|  |  |
| --- | --- |
|  | White and Black Caribbean |
|  | White and Black African |
|  | White and Asian |
|  | Any other mixed background please write below |

|  |
| --- |
|  |

E Chinese or other ethnic group

|  |  |
| --- | --- |
|  | Chinese |
|  | Any other please write below |

|  |
| --- |
|  |

Request Declined

|  |
| --- |
|  |

C Asian or Asian British

|  |  |
| --- | --- |
|  | Indian |
|  | Pakistani |
|  | Bangladeshi |
|  | Any other Asian background please write below |

|  |
| --- |
|  |

What country were you born in? ………………………………………………………………………………………...

What is your first language? ………………………………………………………………………………………………

What language(s) do you write? ………………………………………………………………………………………….

Which religion do you consider yourself to be? …………………………………………………………………………

Do you require an interpreter? Yes No

If yes, what language do you require the interpreter to speak? ……………………………………………………….

NEW TO PRACTICE FORM (HEALTH VISITOR)

Mother’s Name: ………………………………………………………………………………………………….

Date of Birth: ……………………………..… Telephone: …………………………………………………….

Father’s Name: ………………………………………………………………………………………………….

Date of Birth: ……………………………..… Telephone: …………………………………………………….

Address: …………………………………………………………………………………………………………..

………………………………………………………………………………………………………………………

|  |  |  |  |
| --- | --- | --- | --- |
| Childs Name | Date of Birth | Male or Female | School/Nursery |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

If more space is required, please continue on the reverse

Previous Address ………………………………………………………………………………………………..

……………………………………………………………………………………………………………………..

Previous GP ……………………………………………………………………………………………………..

Previous GP Address ……………………………………………………………………………………………

Previous School …………………………………………………………………………………………………

*For office use only:*

*Date received by HV: ……………………..*