**BEECHWOOD SURGERY**

Child New Patient Health Questionnaire

**Details of Person filling in the form**:-

|  |  |
| --- | --- |
| What relationship do you have to this child (eg. Parent, Step Parent, Guardian, Foster Carer): | Surname:  First Name:  Address: |

**Child’s Details**

|  |  |
| --- | --- |
| Surname: | First Name: |
| Date of Birth: | Sex: Male / Female |
| Address: (if different from above) | Home Tel: |
| Main Language:  If not English, is English spoken **YES / NO**  **Do you need a translator? If yes please specify the** language \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Ethnicity: |
| Child’s Country of Birth: | If from overseas, when did the child enter the country: |

**Family Details:**

|  |  |
| --- | --- |
| Mother’s Full Name:  DOB | Father’s Full Name  DOB: |
| Names and DOB of siblings:- | |
| Address of mother / father \* (if different from child’s): \* delete as appropriate | |
| Name and relationship of child of any other household members: (ie Grandparents, Aunts/Uncles) | |
| Name & Address of most recent school or nursery: | |

**Medical History**

|  |  |  |  |
| --- | --- | --- | --- |
| Has your child had any operations, major illnesses or chronic illnesses such as Asthma or any disabilities:- **YES / NO**  If YES, please list with dates:- | | | |
| Any Current or regular medication:- **YES / NO**  If YES, please give details below:- | | | |
| Name of Medication | Daily dosage | How long have you been taking these medications? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Is your child allergic to anything? **YES / NO**  If YES, please list below:- | | | |
| **Immunisations** – Please provide the Red Book OR if you are registering a child who has been born or lived outside of the UK, please provide full details of all the immunisations your child has received.  Has your child had their MMR injection: **YES / NO** | | | |

**Families Receiving Additional Support**

|  |
| --- |
| 1. Does your child have a social worker? YES / NO   If Yes, please give their name, address & contact number |
| 1. Is the child in a care home or fostered? YES / NO |

**Who has Parental Responsibility**

|  |
| --- |
|  |

**SUMMARY CARE RECORD** This will be created as part of your registration and can be used in emergency care anywhere in England with your permission. If you require further information please ask at Reception.

**PATIENT CONTRACT**  Please be aware that you may be asked for a brief description of your reason for booking an appointment; this is not meant to be intrusive, but to ensure that your request is dealt with as quickly and efficiently as possible, and that you are booked with the right clinician (doctor, nurse practitioner, or nurse).

We request that you agree to the following:

* Attend all booked appointments and arrive on time. If you are unable to attend please cancel at least 2 hours before the appointment time. This is so that we can accommodate other patients who need to be seen by clinicians. **Repeated non-attendance could result in removal from the practice register.**
* Inform the surgery of any change in personal details ie: name, address, telephone number as we may need to get in touch with you urgently.
* Be polite at all times; we have a Zero Tolerance Policy with regard to any form of aggressive or abusive language or behaviour towards any doctors or staff at this practice.
* Please do not get annoyed with the receptionist if your appointment time is delayed. Although we endeavour to run clinics on time, the individual clinical needs of each patient can sometimes cause a delay which is beyond our control.

**Patient Signature** **Date**

**Please print name**

Thank you for completing this questionnaire.

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SURGERY USE ONLY

**Appointment with**

Doctor -

Nurse/HCA -

No appointment needed -