# New Patient registration & health questionnaire - Child

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| **Gender:** |  | **Date of birth** |  |
| **Forename(s)** |  |
| **Surname** |  | **Calling Name** |  |
| **Current address** |  |
| **Home phone number** |  |
| **School** |  |
| **NHS number** |  |
| **Previous address** |  |
| **Previous GP** |  |
| **Has your child been registered here previously? If yes, please give dates.** |  |
| **Has your child moved to the UK from abroad? If yes, give date of arrival in the UK.** |  |
| **Parent or Guardian details:****Title:****Surname:****Forename:****Relationship:****Address:****Telephone numbers:** |  |
| **Consent: (Please delete as appropriate)** | I consent / do not consent to be contacted by SMS on my mobile number I consent / do not consent to be contacted by email at this addressWe may contact you with appointment details, results, health awareness events, etc.  |
| **Special circumstances:** | Please tick if any of the following apply to your child:I have a carer I am a carerI have communication difficultiesAsylum seekerHouseboundLive in a nursing homeLive in a residential homeLive in a community psychiatric homeLive in a children’s home |
| **Height** |  | **Weight** |  |
| **Allergies** |  | **Disabilities** |  |
| **Is your child:****Registered blind or partially sighted****Registered deaf****Registered disabled** | Please state which of these apply: |
| **Please state your child’s ethnicity** |  |
| **Does your child have any drug allergies?*****Please include known reactions*** |  |
| **Does your child have any other allergies?*****Please give as much detail as possible*** |  |
| **Does your child suffer from any of the following:****Asthma****Depression****Diabetes****Epilepsy** | Please state which of these apply and give date of last review: |
| **Does your child have any other serious or chronic illness?** | Please explain: |
| **Does your child have a family history of:****Asthma****Diabetes****Heart disease****High cholesterol****Heart attack****Stroke****Cancer****Liver Disease****Depression****Epilepsy****CPOD**  | Please give details including relationship, illness and age at diagnosis if known: |
| **Has your child had any significant injuries or major operations?** | If yes, please give details: |
| **Current medication** | If possible, attach a copy of your child’s repeat prescription list. |
| **Medication** | Dosage / Repeat / Quantity Remaining |
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| **PARENT OR GUARDIAN DECLARATION** |
| **I confirm that, to the best of my knowledge, the information I have provided is accurate and correct.** |
| **Signature** |  |
| **Print name** |  |
| **Date** |  |

**Please note, it is your responsibility to keep the practice up to date with any changes to your address, telephone number or email address.**

Thank you for completing this form.

Please return this form to a member of the reception team who will make an appointment for your new patient health check