# 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 address  We 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 carer  I have communication difficulties  Asylum seeker  Housebound  Live in a nursing home  Live in a residential home  Live in a community psychiatric home  Live 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