**NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE FOR CHILDREN**

**To the Parent/Guardian:**

To register with the practice, please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your Child’s health which will help in any future treatment. All information supplied is confidential.

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

Date of Birth: ……………………………………………………..

Address: ……………………………………………………………………………………………………………………………………………………

………………………………………………………………………………..……………………… Postcode: .......................…………..……

Home tel: …………………………………………..…………..…… Mobile: ………………………………….…………………………….…..

Email address: ……………………………………………………………………………………..……………………………………………………

Weight (approx): ………………………………………………….. Height: ……………………………………..……………………………..

NHS Number: ………………………………………………………… Religion:………………………………………………………………….

Form completed by ………………………………………………………………………………………………………………………………

Relationship to Child (please circle) Parent/Guardian/Carer/Other..……………………………………..

Date of completion of form …………………………………..

Please indicate below your Child’s ethnic origin.

**Ethnic Origin**

A British or Mixed British

B Irish

C Other White Background

D Indian or British Indian

E Pakistani or British Pakistani

F Bangladeshi or British Bangladeshi

G Caribbean

H African

I Other Black Background

J White and Black Caribbean

K White and Black African

L White and Asian

M Other Mixed Background

N Other Asian Background

O Chinese

P Other

Q Information Refused

First language: …………………………………………………………………………………………………………………………………………

If your first language is not English, do you require an Interpreter? ………………………………………………………..

**Is your Child’s gender identity the same as the gender they were given at birth?**

Yes ☐ No ☐

**Accessing the surgery the information we provide to patients**

Does your Child have a disability? Yes/No

If yes, please specify ………………………………………………………………………………………………………………………………

Do they have any information or communication needs? Yes / No (please circle)

If yes, please specify ………………………………………………………………………………………………………………………………..

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

**Family History**

Is there any of the following in your family? (Please tick any that apply)

|  |  |
| --- | --- |
| Ischaemic Heart Disease |  |
| Stroke |  |
| Diabetes |  |
| Cancer |  |
| Asthma |  |
| Hypertension |  |

**Medication**

Please give details of any medication which you take (prescribed or otherwise)

|  |  |
| --- | --- |
| **Name of Drug** | **Dosage** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Your Child’s prescription can be sent electronically to a pharmacy of your choice. If you would like to register for this service, please provide the name and address with the pharmacy of your choice:**

The Pharmacy I nominate is ...........………………………………………………………………………………………………………..

**Allergies**

Does your Child have any allergic to any substances or foods? Yes / No (please circle)

If Yes, please give details:

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

**Past Medical History**

Please give details of any hospital treatment as an in-patient:

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

Please give details of any treatment for any long term medical conditions:

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

**Text Messaging**

Our free text message service continues to prove very popular with patients. It has quickly become the preferred method of communication for many patients who receive appointment confirmations and reminders as well as health promotion information and also provides the ability to cancel an unwanted appointment. To utilise this service simply let us have your mobile phone number and sign the consent below.

Name …………………………………………………………………………… Mobile Number ……………………………………………

Signature ……………………………………………………………………... Date …………………………………………………………….

**Summary Care Record**

Care professionals in England use an electronic record called the Summary Care Record (SCR). This can provide those involved in your care with faster secure access to key information from your GP record. You can choose to share or not to share your full electronic record with other NHS care services where you are treated. If you choose to make your Child’s record shareable, their clinical details will only be viewable by clinical teams who are treating them. Each clinical team which cares for your Child now or in the future will ask your permission to view their shared record. All record accesses are recorded and auditable. If you require further information, you can download it here: [www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/2016/SCR-patient-leaflet.pdf](http://www.nhs.uk/NHSEngland/thenhs/records/healthrecords/Documents/2016/SCR-patient-leaflet.pdf)

If you would prefer your Child’s clinical information to be withheld from the Summary Care Record **(not recommended as NHS health care staff caring for you may not be aware of your current medications, allergies and bad reactions you may have had to any medicines),** please sign below:

I want my Child’s clinical information to be withheld from the Summary Care Record: (***Only applicable to age 13 and under. Any Child over the age of 13 must sign their own consent.)***

Signature ……………………………………………………………………………………… Date ………………………………………………

Thank you – please now take the completed form to Reception.

**For office use:**

*Name of member of staff who has received form……………………………………………………………………………………………..*

*Date …………………………………………*