BANKS AND BEARWOOD MEDICAL CENTRE

NEW PATIENT (Under 16 years of age) QUESTIONNAIRE

Contact Details

Name:

Date of birth:

Previous surname (if any)

Place of birth:

Address:

School:

Telephone no:

Mobile no:

Additional details

Do you suffer from any form of disability if so please give details.

Do you have any specific communication needs (not including foreign language needs)? ☐ Yes ☐ No
If yes: Please ask Reception for the additional Communication Questionnaire.

Next of kin

Name:

Tel. contact number:

Relationship:

Personal Medical History

Type of Birth:
(eg normal, forceps, Caesarean If currently under 5 years of age)

Birth Weight:
(If currently under 5)

Feeding:
(Breast or bottlefed If currently under 5)

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	**Year diagnosed**	**Ongoing**
		Yes/No
		Yes/No

Family History

Have any <u>close relatives</u> (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

List of current medication

Please provide a repeat prescription slip if possible.

Name of medication	Dosage

Allergies

Please list any allergies you have to any drugs/medication:

Name of medication	What was the problem or upset?

Immunisations

Immunisation	Date of 1st Immunisation	Date of 2nd Immunisation	Date of 3rd Immunisation	Date of Booster
Diphtheria, tetanus, pertussis, polio and Hib				
Rotavirus				
Pneumococcal				
Meningococcal Group B				
Meningococcal Group C				
Hib and Men C booster				
MMR (Measles, Mumps and Rubella)				
Diphtheria, tetanus, pertussis and polio				
HPV (cervical cancer) – females only				
Meningococcal A, C, W and Y				
Tetanus, diphtheria and polio				

Ethnicity and Language

Please indicate your ethnic origin:

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian
☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Other (please state):
☐ Decline to state

Please indicate your first language:

☐ English ☐ Welsh ☐ French ☐ Spanish ☐ German ☐ Italian ☐ Polish ☐ Russian
☐ Dutch ☐ Swedish ☐ Greek ☐ Portuguese ☐ Hebrew ☐ Arabic ☐ Hindi ☐ Swahili
☐ Urdu ☐ Punjabi ☐ Cantonese ☐ Mandarin ☐ Japanese ☐ Thai
☐ Other Main Spoken Language: provide details

Data sharing consent choices

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (e.g. Emergency Departments). Please read the accompanying Data Sharing leaflet which details which part of your record is extracted and how it is used to help other NHS organisations, and complete the Consent / Opt Out form.

Signature

I confirm that the information that has been provided is true to the best of my knowledge.

Signed: ☐ Date: ☐

Signature of patient ☐
Signature on behalf of patient ☐ State relationship to patient …………………………………………………………………………….