## New Patient Questionnaire (under 16 years of age)

Glenpark Medical Practice welcomes all people who live in our practice area. We would be grateful if you would complete this confidential questionnaire which we give to every new patient aged under 16 years registering with the practice.

Once the completed form is returned, along with the purple registration form (GMS1), we will be able to proceed with registering your child with the practice.

We require all patients registering with us to attend a “new patient consultation appointment”. This is a meeting with a Practice Nurse which helps us give your child the best care and attention possible. As part of registration, we will inform your Health Visitor or School Nurse that you have changed doctors and registered your child with our practice.

*By giving us contact details, you are giving us permission to use these details to contact you in relation to managing your health.*

Thank you.

# Your Child’s Details

Surname

First Name(s)

Title

What name would you prefer us to use when we call you?

Date of birth

NHS Number (If known)

Home Address

School / Nursery (if appropriate)

Health Visitor / School Nurse (if known)

What is your child’s gender?

What pronouns would you prefer us to use?

⬜ Him / His ⬜ She / Her ⬜ They / Them ⬜ Other:

If 12 years or over, what is the child’s mobile number?

What is your child’s ethnic group?

What is your child’s language?

If your main language is not English, do you need an interpreter? ⬜ Yes ⬜ No

Is the child/young person, a Young Carer ⬜ Yes ⬜ No

# Additional Needs

Do you have any other additional accessible needs?

 ⬜ Registered Blind or other visual loss

 ⬜ Require large font ⬜ Do not write to me

 ⬜ Send written information by email

 ⬜ As plain text ⬜ As a PDF

⬜ d/Deaf

⬜ Sign Interpreter Needed ⬜ Lip Read ⬜ Do not phone me

 ⬜ I need a carer or communicator to come with me to appointments:

 ⬜ Name: ⬜ Phone:

 ⬜ Other needs:

*We will endeavour to meet these needs and will discuss them with you at your new patient appointment. Some needs, such as Braille, we are currently unable to provide, though we constantly review how we can better support patients with additional needs.*

# Parent or Guardian Details

### Mother or Parent 1

Surname Title

First Name(s)

Home Telephone

Work Telephone

Mobile Telephone

Relationship to the child

Do you have parental responsibility?

### Father or Parent 2

Surname Title

First Name(s)

Home Telephone

Work Telephone

Mobile Telephone

Relationship to the child

Do you have parental responsibility?

# **Child’s Past Medical History**

(please list any significant health problems/illnesses and any operations your child may have had e.g. asthma, diabetes, back pain, etc)

|  |  |
| --- | --- |
| **Date** | **Illness/operation** |
|  |  |

# Drugs and Medicines

Is your child prescribed any medication on a repeat basis? ⬜ Yes ⬜ No

Please list any medication taken, including any medicines or remedies bought over the counter (alternatively you could show us your repeat prescription)

|  |  |
| --- | --- |
| **Name of Medication** | **Dose** |
|  |  |

Birth History Please complete for preschool children:

Birthweight: lb oz or kg

Born at ⬜ Home Hospital (which?)

Was (s) born ⬜ On Time ⬜ Early / Late (by how much?)

Was labour induced? ⬜ No ⬜ Yes

How was your child born ⬜ Normal delivery ⬜ Forceps

 ⬜ Ventouse (Suction)

 ⬜ Caesarian Section:

⬜ Emergency ⬜ Planned

Any problems afterwards? ⬜ No ⬜ Yes If yes, please give details:

# **Immunisations**

Has your child had the following immunisations? (Please include the date if you can remember)

Primary Immunisations: 2 months old ⬜ Date

 3 months old ⬜ Date

 4 months old ⬜ Date

Meningitis / Men C\* 12 months old ⬜ Date

MMR (& pneumococcal booster\*) 13 months old ⬜ Date

Preschool Booster (including MMR) 3 ½ - 5 years ⬜ Date

*\*Not all children will have these. It will depend on when your child was born. From 2011, the 12 and 13 month old boosters were merged into one.*

Other immunisations (some children may have received other vaccinations, usually when the routine schedule has been changed or for holidays):

|  |  |
| --- | --- |
| **Date** | **Vaccine given** |
|  |  |

**Allergies**

Is your child allergic to any medicines? ⬜ No ⬜ Yes

Is your child allergic to any thing else (eg nuts) ⬜ No ⬜ Yes

If yes, please give details of any allergies:

Family History

Other than you and your child, who else lives at home:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Age** | **Relationship** | **Occupation / School** |
|  |  |  |  |
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Is there a family history of any of the following conditions)

Heart Disease ⬜ Stroke ⬜ High Blood Pressure ⬜ Asthma ⬜ Diabetes ⬜

Other?.............................................................................................................................................

Please give details …………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….

## Mobile Text Reminders

For reasons of confidentiality, text reminders will not be sent to parent’s mobiles once a child turns 12 years of age. Young people aged 12 years and above may register their own mobiles with the practice, but must do so in person at the practice.

Parents and legal guardians can also apply for online access to appointment bookings, repeat medication and records access. This will be stopped when a child turns 11; at this age a parent may reapply but this may require a conversation each year with you and the young person

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