New Patient Questionnaire – Under 12

We would be grateful if you could complete this form when you register with our practice. It usually takes a number of weeks before your medical records arrive, so this form can help us with essential medical information about you.
The information you supply will be treated with the strictest confidence, but if there is anything you would prefer not to answer then please leave the relevant section blank.
If you have any difficulty with any of the questions the receptionists may be able to help.

Have you been registered with this practice at any time in the past? Yes □ No □

If yes, what year did you leave this practice? _____

Surname: _____ Title: Mr. □ Miss □

Forenames: _____ Sex: Male □ Female □

Address: _____

_____

Postcode _____ Ethnic Origin: British or mixed British □ European □

Date of birth _____ Afro Caribbean □ Chinese □

NHS No: _____ Indian □ Other (Please state) _____

Telephone: _____

Mobile: _____ Email Address: _____

I wish to register for Online Services (e.g. appointment booking, repeat prescription requesting) Yes □ No □

I wish to be contacted by the Practice via text/email Yes □ No □

(Please note your child's Online Services registration will expire on their 16th birthday and new contact details will have to be provided in order for them to set up their own account access)

Data Sharing

I wish for my medical records to be uploaded to the Summary Care Record (SCR) system Yes □ No □

I wish for my medical records to be shared with care.data system Yes □ No □

(If you answer No to either of the above questions about data sharing, please complete the relevant form(s), available from Reception)

Name(s) of other persons living in house:

Past Medical History

Past Medical Problems	Year
1.	
2.	
3.	
4.	
5.	

Have they had any of the following?	
Diabetes □	Jaundice □
Heart disease □	Arthritis □
Rheumatic fever □	Asthma □
Kidney disease □	Epilepsy □
High blood pressure □	T.B. □

Previous Operations

Please list all previous operations	Year	Place
1.		
2.		

Vaccinations - *type*	Year
Tetanus □	
Polio □	

3.		
4.		
5.		

Hepatitis A ☐	
Hepatitis B ☐	
Influenza ☐	

Drugs and medication history

Are they taking any drugs? *(Include inhalers, creams, aspirin, eye drops and drugs bought regularly from the chemist)*		
Name	Dose	How often?
1.		
2.		
continued		
3.		
4.		
5.		

Are they allergic to any drugs?	
Name	Adverse effect

Do they have any other allergies?

Family History

	Alive + well	Alive + problem	Illness or problem	Deceased	Age at death	Cause of death
Father	☐	☐		☐		
Mother	☐	☐		☐		
Brothers	☐ ☐ ☐	☐ ☐ ☐		☐ ☐ ☐		
Sisters	☐ ☐ ☐	☐ ☐ ☐		☐ ☐ ☐		

Do any of their relatives *(blood relations only)* have any of the following illnesses?

Heart disease starting before age 60 ☐ Heart disease starting after age 60 ☐ Diabetes ☐ Glaucoma ☐

Asthma ☐ Thyroid disorder ☐ High blood pressure ☐ High cholesterol ☐ Osteoporosis ☐ Breast cancer ☐

(specify)_____Other problems_____

Next of Kin Name	Relationship	Address & Contact number

Children Under 12

Are they fully immunised?

Which school/nursery does your child attend?

Are there any problems at school?