STOVELL HOUSE SURGERY

NEW PATIENT QUESTIONNAIRE (Under age 14)

Please complete in CAPITAL LETTERS   * These details are mandatory

* First name(s)…………………………………………………………………………………………………..

* Surname……………………………………………………………………………………………………….

* Sex Male ☐ Female ☐ * Date of Birth…………………………………………………………………

* Address………………………………………………………………………………………………………..

……………………………………………………..…Post Code………………………………..…………..

* Contact telephone number:
Home……………………………………….…………….Mobile…………………………………………………..

* Parent/Guardians Name………………………………………………………………………………………

Carers name (if applicable)…………….…………………………………………………………………………

* Please circle/tick one description below which best describes the child's ethnicity

White	White British	☐
	White Irish	☐
	Any Other White Ethnic Group	☐
Mixed	White & Black Caribbean	☐
	White & Black African	☐
	White & Asian	☐
	Any other Mixed background	☐
Asian or Asian British	Indian	☐
	Pakistani	☐
	Bangladeshi	☐
	Sri Lankan	☐
	Any other Asian background	☐
Black or Black British	Caribbean	☐
	African	☐
	Any other Black background	☐
Other Ethnic Group	Chinese	☐
	Any other Ethnic group	☐

Are you able to consult with the GP in English? Yes ☐ No ☐
If not what is your main spoken language?...
Do you have any communication needs? ie BSL, texting, large font, braille Yes ☐ No ☐

* Do You Smoke?............. Yes ☐ No ☐ If **YES** How many cigarettes per day?....................... ☐

* **Height & Weight**

Height:		Weight:		Waist:	

Please be as accurate as possible

IMMUNISATIONS
Please indicate which immunisations the child has had. The exact dates they were carried out and whether they were done at the previous doctor's surgery, a health authority clinic or elsewhere.

Details can be found in the back of the red Child Development book.

IMMUNISATION	Date	G.P	Clinic
1st Diptheria, tetanus, polio			
1st Whooping cough			
1st HIB			
1st Meningitis C			
2nd Diptheria tetanus, polio			
2nd Whooping cough			
2nd HIB			
2nd Meningitis C			
3rd Diptheria, tetanus, polio			
Pneumococcal			
3rd Whooping cough			
3rd HIB			
3rd Meningitis C			
Measles, mumps, rubella (MMR)			
Pre-school booster			
MMR booster			

CHILDHOOD ILLNESSES

Has the child had any of the following illnesses?

Asthma	Yes☐ No☐	Hay Fever	Yes☐ No☐	Chicken pox	Yes☐ No☐
Measles	Yes☐ No☐	Diabetes	Yes☐ No☐	Kidney problem/cystitis	Yes☐ No☐
Mumps	Yes☐ No☐	Heart disease/murmur	Yes☐ No☐	Epilepsy/fits	Yes☐ No☐
German Measles	Yes☐ No☐	Eczema	Yes☐ No☐	Tumours	Yes☐ No☐
Physical Handicap	Yes☐ No☐	Mental Handicap	Yes☐ No☐		

Please list any hospital admissions, with the reason and (approximate) date(s): ……………………………….
……..
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Has the child attended any hospital outpatient clinics, or is he/she currently attending such a clinic? Please give details: ……………………………………………………………………………………………………
…….
…….

MEDICATION
Please list any **REPEAT** prescribed medication the child is taking:………………………………………………
……
……

Is he/she **ALLERGIC** to any medicines? Yes ☐ No ☐

If Yes please give details:……………………………………………………………………………………….
……..