Dr V Patel Surgery
9 Glanville Drive, Hornchurch, RM11 3SZ (01708 442117)
www.drvpatelsurgery.nhs.uk

In order to be fully registered with Dr V Patel, this form MUST be completed by the parent/guardian

NEW PATIENT HEALTH QUESTIONNAIRE (FOR 6 TO 15 YEAR OLDS)

TITLE:		**FIRST NAME:**	
SURNAME:			
DATE OF BIRTH:		**GENDER:**	**M** ☐ **F** ☐ (please tick)
ADDRESS (incl flat no):		**ANY OTHER SURGERY PATIENTS LIVING AT THIS ADDRESS?**	**Please give names:**
		IS YOUR CHILD THE LONE OR PARTIAL CARER FOR SOMEONE? If yes, please specify:	**YES** ☐ **NO** ☐ (please tick)
HOME TEL:		**MOBILE TEL:**	
EMAIL ADDRESS:			
WHO DO THESE DETAILS BELONG TO? (e.g. mum, dad, child etc.)	**MOBILE:**		
	EMAIL:		
CAN WE LEAVE MESSAGES REGARDING YOUR CHILD ON THESE NUMBERS?	**HOME:**	**YES** ☐ **NO** ☐ (please tick)	
	MOBILE:	**YES** ☐ **NO** ☐ (please tick)	
NEXT OF KIN: (Name, Address, Tel No.)			

Pharmacy Details (name and address of preferred pharmacy)

Summary Care Record Consent		
Medication, allergies and adverse reactions only	**YES** ☐ **NO** ☐	(please tick)
Medication, allergies, adverse reactions and additional	**YES** ☐ **NO** ☐	(please tick)
Dissent – Patient does not want a summary care record	**YES** ☐ **NO** ☐	(please tick)

FAMILY HISTORY

Has a first degree relative of your child (parent or sibling) suffered from any of the following conditions? (please tick)

Cancer	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Stroke	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Heart Disease	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	
Diabetes	**YES** ☐ **NO** ☐	**Who?**		**At what age?**	

Do any other illnesses run in your family? YES ☐ **NO** ☐

If Yes, Please give details:

MEDICAL HISTORY

Has your child had/still have any of the following conditions? (please tick) **:**

High Blood Pressure (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Diabetes** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Heart Disease (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Angina** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Epilepsy (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Stroke** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
Asthma (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐	**Cancer** (Please add approximate date of diagnosis if known)	**YES** ☐ **NO** ☐
If Asthmatic, have you used your inhaler in past 12 months?	**YES** ☐ **NO** ☐		

Please give details of any other illnesses, accidents, hospital admissions, investigations or operations your child has had :

	Date:
	Date:
	Date:
	Date:

MEDICATION

IS YOUR CHILD ON ANY REGULAR MEDICATION?	**YES** ☐ **NO** ☐ (please tick)

If Yes, please state name and dose or attach the most recent repeat reorder form

(Please note they will be required to see the doctor for a first repeat prescription to be issued)

IS YOUR CHILD ALLERGIC TO ANY MEDICINES?	**YES** ☐ **NO** ☐ (please tick)

If Yes, please state type and name:

Does your child have a disability? ☐ Yes ☐ No ☐ Decline to specify

The Disability Discrimination Act 1995 states 'a person has a disability for the purpose of this ACT if he/she has a physical or mental impairment, which has a substantial and long-term adverse effect on his/her ability to carry out day to day duties.

Ethnic Origin
This is not about nationality, place of birth or citizenship. It is about the group to which you perceive your child belongs. Please tick the appropriate box

White
English ☐ Welsh ☐ Scottish ☐ Northern Irish ☐ Irish ☐ British ☐
Prefer not to say ☐ Any other white background, please write in:

Mixed/multiple ethnic groups
White and Black Caribbean ☐ White and Black African ☐ White and Asian ☐
Prefer not to say ☐ Any other mixed background, please write in:

Asian/Asian British
Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Prefer not to say ☐
Any other Asian background, please write in:

Black/ African/ Caribbean/ Black British
African ☐ Caribbean ☐ Prefer not to say ☐
Any other Black/African/Caribbean background, please write in:

Other ethnic group
Prefer not to say ☐ Any other ethnic group, please write in:

Is an interpreter or sign language support needed? **Yes** ☐ **No** ☐

Registration form checked and accepted by: _____

Date: _____/_____/_____