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 CHILDREN UNDER 6Y)

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:**
HOME TEL:		**MOBILE TEL:**	
EMAIL ADDRESS:			

WHO DO THESE DETAILS BELONG TO? (e.g. mum, dad 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.)		

PREVIOUS ADDRESS:	**PREVIOUS GP NAME & ADDRESS:**

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)

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:

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:

Please note **without immunisation history we are unable to fully register children**. A current photocopy of the immunisation history is the preferred option; we can take a photocopy of this at reception. If this is not available then please list below.

IMMUNISATIONS	DATE GIVEN
1st Diphtheria, Tetanus, Pertussis (Whooping Cough) / Polio / Hib	
2nd Diphtheria, Tetanus, Pertussis (Whooping Cough) / Polio / Hib	
3rd Diphtheria, Tetanus, Pertussis (Whooping Cough) / Polio / Hib	
1st Rotavirus	
2nd Rotavirus	
1st Meningitis B	
2nd Meningitis B	
3rd Meningitis B	
1st Meningitis C	
2nd Meningitis C (if applicable)	
3rd Meningitis C (if applicable)	
1st Pneumococcal conjugate	
2nd Pneumococcal conjugate	
3rd Pneumococcal conjugate	
Other Pneumococcal (if applicable)	
Hib / Meningitis C	
1st Measles, Mumps, Rubella (MMR)	
Booster Diphtheria, Tetanus, Pertussis (Whooping Cough) / Polio / Hib	
Booster Measles, Mumps, Rubella (MMR)	
BCG	
Details of any other immunisations:	

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: _____/_____/_____

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Dear Parent

In order to ensure the continuation of the health visiting service we ask you to complete this form. This information will then be passed on to your Health Visitor.

Thank you.

Mother's name: ……

Father's name: ……

Children's names, dates of birth & School/Nursery attended:

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Present Address & Tel No. ……

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Previous GP and address of surgery:

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Comments/information the health visitor needs to know:

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