**New Patient Questionnaire: Children or Young People aged below 18 (To be completed with GMS1)**

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| **PERSONAL DETAILS** | | | | |
| **Name:**  **Preferred name(s):** | | | **NHS Number:** | |
| **School/nursery:** |  | | | |
| **Religion**  (*Please circle)* | Christian Buddhist       Hindu Jewish Muslim Sikh  Any other religion, please describe: | | | |
| **Do you or the child consider them to have a disability?**  *(Please Circle)* | No  Yes: Physical Sensory Learning Disability Mental Health  Other: | | | |
| **Ethnicity**  (*Please circle)* | **White**  British  Irish  Gypsy or Irish Traveller  Any other White background, please describe: | | | **Mixed/Multiple ethnic groups**  White and Black Caribbean  White and Black African  White and Asian  Any other Mixed/Multiple ethnic background, please describe: |
| **Asian/Asian British**  Indian  Pakistani  Bangladeshi  Chinese  Any other Asian background, please describe: | | | **Black/ African/Caribbean/Black British**  African  Caribbean  Any other Black/African/Caribbean background, please describe: |
| **Other ethnic group**  Arab  Any other ethnic group, please describe: |
| **First language:** | | **Immigration status:** | | |

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| **COMMUNICATION REQUIREMENTS** | | |
| **Does the child require any of the following:**  *(Please circle all that apply)* | I need an Interpreter  I use lip reading  I use textphone / Minicom | I need large print  I rely on British Sign Language |

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| **PARENT / CARER (S) DETAILS** | | | | | | | | | |
| **Person (s) with Parental Responsibility:** | | | | | | | | | |
| **Name:**  **DOB:**  **Address** *if different to child:*  **Contact No:**  **Relationship to child:** | | | | | **Name:**  **DOB:**  **Address** *if different to child:*  **Contact No:**  **Relationship to child:** | | | | |
| **Main carer details** *(if different to person with parental responsibility)* | | | **Name:**  **DOB:**  **Address** *if different to child:*  **Contact No:**  **Relationship to child:** | | | | | | |
| **Is the child subject to any legal orders?** (*Please circle) Please give details* | | | | | | | Yes No | | |
| **MEDICAL HISTORY** | | | | | | | | | |
| **Child Health and Development:**  *(Please circle)*  Hearing problems  Vision Problem  Seizures in Childhood  Literacy Problems  Allergies  Hip Problems  Heart Conditions  Asthma  Diabetes  Contact with Tuberculosis  Infectious Diseases  Cancer  Mental Health  Other (Please specify) | | **Any further comments:** | | | | | | | |
| **Family medical history:**  *(Please circle and specify who in further comments)*  Hearing problems  Vision Problem  Seizures in Childhood  Literacy Problems  Allergies  Allergies to Medication  Hip Problems  Heart Conditions  Asthma  Diabetes  Contact with Tuberculosis  Infectious Diseases  Cancer  Mental Health  Other (Please specify) | | **Any further comments:** | | | | | | | |
| **Height:** |  | | | **Weight:** | |  | | **BMI:** |  |
| **Specialist Diet / Nutrition required:** | | | | | | **Dental Care / Registered Dentist:** | | | |

**SCHOOL or NURSERY – Please give details**

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| **CURRENT MEDICATION** *(Please list)* | |
| **Health Condition** | **Medication Required** |
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| **IMMUNISATION HISTORY** | |
| **Immunisation** | **Date Given** |
| BCG |  |
| 1st Diptheria/ Tetanus/ Pertussis/ Polio/ Hib  1st Pneumococcal  1st Rotavirus |  |
| 2nd Diptheria/Tetanus/Pertussis/Hib  1st Meningitis C  2nd Rotavirus |  |
| 3rd Diptheria/Tetanus/Pertussis/Hib  2nd Pnemococcal |  |
| Hib/Meningitis C  MMR 1  Pneumococcal booster |  |
| Diptheria/Tetanus/Polio/Pertussis booster |  |
| MMR 2 |  |
| HPV (Girls only) |  |
| Diptheria/Tetanus/Polio booster  Meningitis C booster |  |
| Other |  |

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