**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 HealthOther:  |
| **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 readingI use textphone / Minicom | I need large printI 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 problemsVision ProblemSeizures in ChildhoodLiteracy ProblemsAllergiesHip ProblemsHeart ConditionsAsthmaDiabetesContact with TuberculosisInfectious DiseasesCancerMental HealthOther (Please specify) | **Any further comments:** |
| **Family medical history:***(Please circle and specify who in further comments)*Hearing problemsVision ProblemSeizures in ChildhoodLiteracy ProblemsAllergiesAllergies to MedicationHip ProblemsHeart ConditionsAsthmaDiabetesContact with TuberculosisInfectious DiseasesCancerMental HealthOther (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/ Hib1st Pneumococcal1st Rotavirus |  |
| 2nd Diptheria/Tetanus/Pertussis/Hib1st Meningitis C2nd Rotavirus |  |
| 3rd Diptheria/Tetanus/Pertussis/Hib2nd Pnemococcal |  |
| Hib/Meningitis CMMR 1Pneumococcal booster |  |
| Diptheria/Tetanus/Polio/Pertussis booster |  |
| MMR 2 |  |
| HPV (Girls only) |  |
| Diptheria/Tetanus/Polio boosterMeningitis C booster |  |
| Other |  |

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