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

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| **PERSONAL DETAILS** |
| **Name:****Alternative name(s):** | **Date of Birth:** |
| **NHS Number:** |
| **School:** |  |
| **Religion**(*Please circle)* | Christian Buddhist       Hindu Jewish Muslim Sikh No religionAny other religion, please describe: |
| **Sexual Orientation**(*Please circle)* | Heterosexual / Straight Gay or Lesbian Bisexual Other Prefer not to say |
| **Gender/ Gender Identity** | **Which of the following best describes how you think of yourself?**Female (including trans women)Male (including trans men)Non-binary  | **Is your gender identity the same as the gender you were given at birth?**Yes/No |
| **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:**  |
| **Country of birth:** |
| **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)* | Yes No |
| **Is child considered to be a young carer? If so for whom (i.e parent/grandparent/siblings)** | Yes No |
| **Do you have parental responsibility for children (under Age 18):** | **Yes / No**  |
| **Do you consent to providing the GP practice with details of your children for whom you have parental responsibility? Yes / No****If yes please provide details below:***(Please note that you are entitled to request for the information in this section regarding your children’s details to be removed from this form and associated systems. If you wish for this information to be removed please speak to a member of the GP practice)* |
| **Child name:****Child DOB:****Child Address** *if different to yours:* | **Child name:****Child DOB:****Child Address** *if different to yours:* | **Child name:****Child DOB:****Child Address** *if different to yours:* |
| **Do you have caring responsibilities for children (under Age 18) eg partner’s children:** | **Yes / No**  |
| **Are you pregnant Yes/ No** | **If yes Expected Date of Delivery:** |
| **MEDICAL HISTORY** |
| **Child Health and Development:***(Please circle)*Hearing problemsVision ProblemSeizures in ChildhoodLiteracy ProblemsAllergiesAllergies to MedicationHip 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:** |  |
| **Diet / Nutrition:** | **Dental Care / Registered Dentist:** |

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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 |  |

**NIS**