BOURTREEHILL MEDICAL PRACTICE

Registering Staff Member…..…….

NEW CHILD PATIENT QUESTIONNAIRE

UNDER 15 YRS (to be completed by parent or guardian)

Please answer all questions as fully as possible with a small tick in the appropriate box, provide additional details where requested and return your form to the GP Practice Reception desk. If there is not enough room on the form for your needs, please add comments on a separate sheet.

Please note that it is practice policy that no-one can be registered, and therefore no-one can receive proper services from this practice, until they have handed in this completed questionnaire.

SURNAME……FORENAME(s)……

DATE OF BIRTH…….SEX: Male/Female…….……..

ADDRESS……

POSTCODE…….. TODAY'S DATE……

TELEPHONE Home……Mobile……...

ETHNICITY (Please choose from list below)……..…….…….

1. White Scottish. 2. White Irish. 3. Other White British Ethnic Group. 4. Other White Ethnic Group. 5. Indian. 6. Pakistani. 7. Bangladeshi. 8. Other Asian Ethnic Group. 9. Chinese. 10. Black Caribbean. 11. Black African. 12. Other Black. 13. Other Ethnic, Mixed Origin. 14. Other Ethnic Group.

HAS THE CHILD BEEN REGISTERED WITH US BEFORE? ☐ **YES** ☐ **NO**

HAS THE CHILD HAD ANY MAJOR OPERATIONS/HOSPITAL ADMISSIONS
(give approximate date and nature of any operation)

1. **DRUG ALLERGIES** Please list any drug allergies of which you are aware:

2. **OTHER ALLERGIES** Please list any other allergies of which you are aware:

BOURTREEHILL MEDICAL PRACTICE

3. HEIGHT in feet/inches:……or in metres……

4. CURRENT WEIGHT in stones/pounds……...or in kilos…….…….

5. CURRENT MEDICATION – Please write below any current or repeat prescribed medicines. Please contact us a week after handing in your form to make a routine double appointment with a GP if you are on repeat medication (medicine you take all the time).

Name of drug	**What for?**	**Dose in mgs**	**When?/How often?**
(ie Salbutamol inhaler	Asthma	200mgs	2 puffs as necessary)

1……..……..

2……..……..

3.……..

4……..

6. (IF SCHOOL AGE) - NAME OF SCHOOL CHILD ATTENDS

……..……..……

7. FAMILY HISTORY –THINKING OF CHILD'S PARENTS/BROTHERS/SISTERS

(Delete as appropriate or leave if not sure)
Are any Diabetic? YES/NO
Any had heart attacks or Angina developed: a) Before Age 60 YES/NO b) After Age 60 YES/NO

8. PLEASE ADD BELOW ANY OTHER COMMENTS OR INFORMATION YOU FEEL IS RELEVANT

(OFFICE USE – INITIAL PLEASE) – TO BE SEEN BY GP ☐ or: NFA ☐ DATA ENTRY ☐ SCANNED & TO ARCHIVE ☐