St Paul’s Medical Centre – New Patient Questionnaire – Children Under 16

Welcome to St Paul’s Medical Centre. Please complete this questionnaire clearly using **BLOCK CAPITALS**, one for each child or young person. The information will be treated in strict confidence

**Personal details: (It is VERY IMPORTANT you let us know as soon as possible if any of these details change)**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME TEL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MOBILE (parent):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT NURSERY/SCHOOL: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(state if ‘home schooled’)

PARENTS/GUARDIANS with **LEGAL PARENTAL RESPONSIBILITY**:

Name: ……………………………… Contact number: ………………….…………. Relationship:………………………..

Name: ……………………………… Contact number: …………….………………. Relationship:………………..……..

If there any court orders or restrictions on access to this child’s care or medical records, please give the details below and provide a copy of the court order or legal document.

**ETHNIC GROUP (please tick one)**

White (British) [ ] Black or Black British (Caribbean) [ ]

White (Irish) [ ] Black or Black British (African) [ ]

White (Other) [ ] Black or Black British (Other) [ ]

Asian or Asian British (Indian) [ ] Asian or Asian British (Pakistani) [ ]

Asian or Asian British (Bangladeshi) [ ] Other Asian or Asian British [ ]

Mixed (white & black Caribbean) [ ] Mixed (white & black African) [ ]

Mixed (white & Asian) [ ] Mixed (white & other) [ ]

Chinese [ ] Other ethnic group [ ]

**MAIN SPOKEN LANGUAGE (please specify)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you or your child have any difficulty in speaking or understanding English? YES [ ] NO [ ]

Is this child or young person a carer? YES [ ] NO [ ] If yes, please give details below

A carer is someone who looks after a disabled, ill or frail parent/relative.

Name of person cared for, relationship to patient and reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# **Disabilities & Health:**

Please give details of any disabilities the child or young person has, relating to:

EYESIGHT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is he/she registered blind? YES [ ] NO [ ]

Does he/she need written information in LARGE FORMAT? YES [ ] NO [ ]

HEARING:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ Does he/she use a hearing aid? YES [ ] NO [ ]

Does he/she need to use the LOOP SYSTEM when in surgery YES [ ] NO [ ]

LEARNING: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does he/she need information in EASY READ format with pictures? YES [ ] NO [ ]

Has the child or young person’s **mother, father, brother** or **sister** suffered from high blood pressure, heart problems, stroke or diabetes? If so, please state which disease(s) and which family member(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please bring in your child’s RED BOOK or other vaccination record especially any from outside the UK so we can ensure your child does not miss out on any scheduled vaccinations.

Teenagers

Please answer these additional questions. You can return this sheet separately from the main questionnaire if you wish.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ e-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please be aware that appointment reminders and other information is sent by text or e-mail***

Have you **ever** smoked tobacco? YES [ ] NO [ ]

Do you **currently** smoke tobacco? YES [ ] NO [ ] how many cigarettes per day? \_\_\_\_\_

Do other people regularly smoke near you? YES [ ] NO [ ] you may be ‘passive smoking’

Do you use electronic cigarettes? YES [ ] NO [ ]

We strongly advise all smokers to quit and are happy to help. See your welcome pack for details.

How often, if at all, do you drink alcohol, and what do you usually drink? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you do drink alcohol, please complete the questionnaire below.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Questions** | **0** | **1** | **2** | **3** | **4** | **Your Score** |
| How often do you have a drink that contains alcohol? | Never | Monthly or less | 2 – 4 times per month | 2 – 3 times per week | 4+ times per week |  |
| How many standard alcoholic drinks do you have on a typical day when you are drinking? | 1 – 2 | 3 – 4 | 5 – 6 | 7 – 8 | 10+ |  |
| How often do you have 6 or more standard drinks on one occasion? | Never | Less than monthly | Monthly | Weekly | Daily or almost daily |  |

***Although we will always encourage you to discuss your health concerns with your parents or guardians, we will not insist on this and you can come to us for help and advice in complete confidence.***

Checklist for completed forms:

* Pharmacy nomination: Completed [ ] Not applicable [ ]
* Summary Care Record Completed [ ] Not applicable [ ]
* Terms & Conditions Completed [ ] Not applicable [ ]

Check out our website at [www.stpaulspcc.co.uk](http://www.stpaulspcc.co.uk) for more information about the services we offer and for useful links for information about lots of health related issues. You can also find us on Facebook.