**NEW PATIENT HEALTH QUESTIONNAIRE**

**0 - 16 YEARS INCLUSIVE**

**Castlehead Medical Centre**

**Ambleside Road, Keswick, CA12 4DB**

**Tel 017687 72025**

**PLEASE COMPLETE IN FULL**

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| **TITLE** |  |
| **FIRST NAMES** |  |
| **SURNAME** |  |
| **PREVIOUS SURNAME** |  |

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| --- | --- |
| **ADDRESS**  **POSTCODE** |  |

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| **DATE OF BIRTH** | **MALE FEMALE** |

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| **TEL NO** |  |
| **WORK NO** |  |
| **MOBILE NO** |  |
| **E-MAIL** |  |
| **PARENT /GUARDIAN**  **PARENTAL RESPONSIBILITY NAME (S)** | |  |  |  |  | | --- | --- | --- | --- | | **Name** |  | **Name** |  | | **Address** |  | **Address** |  | | **Date of birth** |  | **Date of birth** |  | | **Contact number(s)** |  | **Contact number(s)** |  | | **Relationship to the child** |  |  |  | |
| **OVER *13YRS* ONLY**  **DO YOU GIVE CONSENT FOR US TO CONTACT YOU IN THE FOLLOWING WAYS (PLEASE TICK)** | **HOME TEL MOBILE NO LETTER**    **DO YOU GIVE US CONSENT TO SPEAK TO YOUR PARENTS/GUARDIAN AS NAMED ABOVE**    **YES NO**  **SIGNED\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **(child to sign)**  **(ONLY VALID UNTIL CHILD TURNS 16 YRS)** |

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| **WHO ELSE LIVES IN THIS HOUSEHOLD** | **MUM DAD STEP PARENT PARENTS PARTNER**  **GRANDPARENTS SIBLINGS HOW MANY? FOSTER CARER**  **GUARDIAN OTHER PLEASE STATE ………………………………………..** |

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| **WHO HAS PARENTAL RESPONSIBILITY?**  **PLEASE GIVE US THEIR NAME, CONTACT DETAILS (IF NOT GIVEN ABOVE) AND THEIR RELATIONSHIP TO THE CHILD.** |  |

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| **ETHNIC GROUP – WOULD YOU DESCRIBE YOURSELF AS…..** | **WHITE BLACK ASIAN MIXED**  **BRITISH CARRIBEAN INDIAN WHITE+BLACK CARRIBEAN**  **IRISH AFRICAN PAKISTANI WHITE+BLACK AFRICIAN**  **CHINESE WHITE+ASIAN**  **OTHER PLEASE SPECIFY …………………………………………………………..** |
| **WHAT IS YOUR FIRST LANGUAGE**  **DO YOU REQUIRE AN INTERPRETER**  **DO YOU HAVE ANY COMMUNICATION NEEDS SUCH AS BRAILLE/LARGE PRINT/EMAIL** | **YES NO**  **PLEASE SPECIFY** |

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| **NAME AND ADDRESS OF YOUR PREVIOUS GP** |  |

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| **HAS THE CHILD LIVED OUTSIDE THE UK IF SO WHERE AND WHEN** |  |
| **HAS THE CHILD BEEN OUTSIDE THE UK IN THE LAST 2 YEARS IF SO WHERE AND WHEN** |  |

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| **PROOF OF IDENTITY** |
| **BIRTH CERTIFICATE** |
| **OFFICE USE ONLY - *IF UNDER 16 YRS AND HAS NO ID REFER TO NHS ENGLAND PATIENT REGISTRATION DOCUMENT*.** |

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| **IS THE CHILD REGISTERED AS DISABLED** | **YES NO** |
| **DOES THE CHILD HAVE LEARNING DIFFICULTIES** | **YES NO**  **IF YES PLEASE STATE WHAT THESE LEARNING DIFFICULTIES ARE :** |
| **DOES THE CHILD HAVE A CARER** | **YES NO PLEASE GIVE DETAILS** |
| **IS THE CHILD A CARER?** | **YES NO PLEASE GIVE DETAILS**  **IF YES PLEASE COMPLETE BELOW**  **NAME**  **ADDRESS**  **TEL**  **RELATIONSHIP TO CHILD** |
| **DOOR ACCESS KEY CODE - IF APPLICABLE** |  |
| **WHO SHOULD WE CONTACT IN CASE OF AN EMERGENCY?** | **NAME-**  **ADDRESS-**  **TEL NO-** |
| **MEDICAL HISTORY** |  |
| **DOES THE CHILD HAVE ANY KNOWN ALLERGIES (IF YES PLEASE STATE)**  **DOES THE CHILD HAVE ANY KNOWN DRUG INTERACTIONS (IF YES PLEASE STATE)** |  |
| **HAS THE CHILD HAD ANY SERIOUS ILLNESSES OR OPERATIONS (IF YES PLEASE STATE)** |  |
| **CURRENT MEDICAL CONDITIONS (PLEASE LIST CONDITION (AND APPROX YEAR DIAGNOSED)**  **DIABETES/ STROKE/ COPD/ASTHMA/ DEPRESSION/ CANCER/ EPILEPSY/**  **MENTAL HEALTH PROBLEMS/ HEART DISEASE/**  **HYPERTENSION/ DEMENTIA/ ATRIAL FIBRILLATION/ KIDNEY DISEASE/ OSTEOPOROSIS/ ARTHRITIS** |  |
| **PLEASE LIST ANY CURRENT MEDICATION FOR THE CHILD**  **NAME/STRENGTH/DOSE** |  |
| **VACCINATION HISTORY**  **PLEASE LIST ALL KNOWN VACCINATIONS** |  |
| **WHICH SCHOOL DOES YOUR CHILD ATTEND**  **NAME**  **ADDRESS**  **TEL NO** |  |

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| **DOES THE CHILD HAVE ANY CONTACT WITH THE FOLLOWING?** | **A HOSPITAL SPECIALIST …………………………………………………………………**  **A HEALTH VISITOR …………………………………………………………………**  **A SOCIAL WORKER …………………………………………………………………**  **ANY OTHER HEALTH PROFFESSIONALS**  **PLEASE STATE …………………………………………………………………** |

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| **HAS THE CHILD EVER BEEN UNDER A CHILD PROTECTION PLAN (SOCIAL SERVICES/ SOCIAL WORKER INVOLVEMENT?** | **YES NO**  **IF YES PLEASE STATE DETAILS :** |

**IMPORTANT:**

**All the information given to the practice as part of this form will be treated as confidential. However, to give your child the very best health care we work closely with the health visiting and school nursing service. It is therefore normal practice to share the details of all children registering with the practice with our NHS colleagues.**

**If you would prefer that we DO NOT share this information as described, please tick here .**

**SIGNATURE OF PERSON WITH PARENTAL RESPONSIBILITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALL CHILDREN UNDER 16 YEARS WITH ANY PRE-EXISITNG MEDICAL CONDITIONS OR WHO ARE ON ANY REGULAR**

**MEDICATION PLEASE MAKE AN APPOINTMENT WITH A GP.**

***Your registered GP will be one of the following***

***Dr J Grove Dr P Hemingway DR T Hooper Dr A Westwell Dr G White***

***Dr K Winterbottom Dr C Ferris Dr C Haslam Dr D Jones***