Alrewas Surgery

New Patient Questionnaire – Under 16s

Please complete as much information as possible and hand this form back to Reception with your other registration documents.

ALL INFORMATION GIVEN IS HELD IN COMPLETE CONFIDENCE

PERSONAL DETAILS

1

Title (Mr, Mrs, Ms, Miss, Master, Dr, etc) ___ **Date of Birth** _____

Forename(s) _____ **Surname** _____

Preferred name _____

Full Address _____

_____

_____ Postcode _____

Telephone Numbers Home _____

Mobile _____

E-mail address _____

Name of person/persons with parental responsibility **1.** _____ **2.** _____

ETHNICITY

1

We have been requested by South Staffordshire Primary Care Trust to record Ethnic Origin.
Please tick the appropriate option. If you choose not to answer please tick this box ☐ Thank you.

White	☐ British ☐ Irish	☐ Other White background
Mixed	☐ White and Black Caribbean ☐ White and Black African	☐ White and Asian ☐ Other Mixed background
Asian or Asian British	☐ Indian ☐ Pakistani	☐ Bangladeshi ☐ Other Asian background
Black or Black British	☐ Black Caribbean ☐ Black African	☐ Other Black background
Other Ethnic	☐ Chinese	☐ Other Ethnic Category

FURTHER DETAILS

Name and Relationship: Contact No.:

Next of Kin _____ 2

Is your child a Carer? ☐ YES ☐ NO **Name of person cared for** _____ 3

Does your child have a Carer? ☐ YES ☐ NO **Name of Carer** _____

Does your child smoke? ☐ YES ☐ NO 4

PERSONAL MEDICAL HISTORY

7

- **ILLNESSES, ONGOING CONDITIONS, FAMILY HISTORY**

Please indicate below if your child or anyone in your family has ever had any medical conditions.

Is there any other information that you think may be relevant in ensuring that your child's medical history is accurate and up to date – e.g. other illnesses, operations, accidents?

If so, please provide details here, including dates:

_____

_____

_____

_____

_____

_____

_____

- **MEDICATION**

8

Does your child take any tablets / use inhalers or other medication? YES / NO If Yes, please give details here:

Name of Tablet or Medication	Dose	Why Taken?	Please tick how many months' supply you currently have left				
			Less than 1	1	2	3	3+

Please continue on a separate sheet if necessary. If you have a repeat prescription request form from your previous surgery, please bring it with you when you register.

- **ALLERGIES**

9

Does your child have any allergies, including drug allergies? YES / NO

If Yes, please give details _____

_____

_____

IMPORTANT INFORMATION

- If your child is on regular prescribed medication, you will need to make an appointment to see one of our Doctors for a prescription to be issued. Please make sure you make an appointment in plenty of time before any of the medication runs out.
- If your child has any of the following conditions, they will be invited to attend an Annual Review in their birth month: Heart problem, Asthma, Kidney disease, Diabetes, Epilepsy, Hypertension, Thyroid disease, Stroke (this list is not exhaustive)

Signed _____Parent/Guardian Date _____

Thank you for taking the time to fill in this questionnaire.
Please hand it in to Reception with your other registration documents.