WHITEHILL & FAIRFORD LEYS SURGERIES PATIENT QUESTIONNAIRE FOR CHILDREN 0-10 YEARS

Thank you for filling out this questionnaire. It is used to help the practice to provide your child with good medical care.
To enable you to register we need official ID such as your passport, red book (for infants), or Birth Certificate.

CHILD'S SURNAME: CHILD'S FIRST NAME:

CHILD'S OTHER NAMES: CHILD'S DATE OF BIRTH:

NAME OF SCHOOL (16 yrs & under) :

CHILD'S PLACE OF BIRTH: SEX OF CHILD: Male/Female

PARENT/GUARDIAN'S NAME: RELATIONSHIP TO CHILD:

ADDRESS: TEL NO:

HOME TELEPHONE NUMBER:

PARENT'S MOBILE NUMBER:
(*text appointment reminders will be sent to you unless you let us know otherwise)*

EMERGENCY CONTACT DETAILS:

WEIGHT OF CHILD: HEIGHT OF CHILD: WAIST SIZE OF CHILD:

RECORDING ETHNIC GROUP INFORMATION: This practice in line with other healthcare providers collects information about the ethnic group of patients. This information will help us plan to meet the health needs of the entire community and ensure that everyone has equal access to the healthcare we provide. The groups have been developed and agreed by the Office for National Statistics in conjunction with the Commission for Racial Equality.
Please tick the one of the boxes below that most accurately describes the ***ethnic*** group you belong to:

White
- British ☐
- Irish ☐
- Any other white background ☐

Mixed
- White & black Caribbean ☐
- White & Black African ☐
- White & Asian ☐
- Any other mixed background ☐

Other ethnic group
- Chinese ☐
- Any other ethnic group ☐

Asian or Asian British
- Indian ☐
- Pakistani ☐
- Bangladeshi ☐
- Any other Asian background ☐

Black or Black British
- Caribbean ☐
- African ☐
- Any other black background ☐

Other: .... ☐

SUMMARY CARE RECORD
Please indicate your choice:

☐ I choose to have a Summary Care Record so that details of my child's medications and allergies are accessible should I visit a clinician elsewhere in the UK

☐ I choose to opt out of having a Summary Care Record and understand that information regarding my child's medication and allergies will not be accessible to other clinicians in the UK

HEALTH INFORMATION

IS YOUR CHILD TAKING OR USING ANY REGULAR MEDICATION AT PRESENT?
PLEASE LIST TYPE AND DOSAGE BELOW:

PLEASE LIST ANY MAJOR ILLNESSES (PAST OR PRESENT), ACCIDENTS AND/OR OPERATIONS:
PLEASE STATE AGE AT TIME OF ONSET

IS YOUR CHILD SENSITIVE TO ANYTHING SUCH AS PENICILLIN, ASPIRIN, PLASTERS ETC?
PLEASE STATE ALLERGY AND HOW IT AFFECTS YOUR CHILD:

HAS YOUR CHILD ANY MAJOR HANDICAP, DISABILITY, SOCIAL PROBLEM OR ANY OTHER MATTER YOU THINK YOUR DOCTOR SHOULD KNOW ABOUT?

IS YOUR CHILD CURRENTLY UNDER HOSPITAL TREATMENT OR ON THE WAITING LIST FOR SURGICAL PROCEDURE? PLEASE GIVE DETAILS:

FAMILY HISTORY:
HAS ANYONE IN YOUR CLOSE FAMILY HAD HEART TROUBLE? *PLEASE STATE AGE OF ONSET:*

IF SO, WHO: MOTHER………. FATHER………. SISTER………. BROTHER……….

IS THERE ANYONE IN YOUR FAMILY WHO SUFFERS FROM: (please specify relationship)

BLOOD PRESSURE ………………. ASTHMA …………………. GLAUCOMA ……………….

STROKE …………………. DIABETES ………………. CANCER ……………………

IMMUNISATION HISTORY:
PLEASE LIST ANY IMMUNISATIONS YOUR CHILD HAS RECEIVED TO DATE (alternatively please bring in immunisation record from red book so that we can photocopy and update your child's medical record accordingly)

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FOR OFFICE USE ONLY:

TYPE OF ID SEEN :…………………………. EXPIRY DATE: ……………………………………….

PROOF OF RESIDENCY WITHIN PRACTICE AREA PROVIDED:……………………………………………………….

DATE ON THIS EVIDENCE: …………………………………….

INFORMATION CHECKED BY ………………………………… DATE:……………………

REGISTRATION AND QUESTIONNAIRE DETAILS INPUT BY …………………………………… DATE ………………………