APPLEBY MEDICAL PRACTICE

Date Form Completed:		Informed of Named GP	

In order to be fully registered with this practice, this form MUST be completed by the parent/guardian

New Patient Questionnaire (for children up to 16yrs)

Title:		First Name:	
Surname:	Current Surname:		
	Any previous Surnames:		
Date of Birth:		Gender:	M ☐ F ☐ (please tick)
Address inc Postcode:		Who else lives in this household?	

Name	Relationship to Child

Home Tel:		Mobile Tel:	
Email Address:			
Ethnicity		Main language spoken	
Who do these details belong to? (e.g. mum, dad etc.)		Email:	
		Home:	
		Mobile:	
Would you like to register with the Practice for SMS text message reminders?		YES ☐ or NO ☐	

Who has Parental Responsibility for this child?
Please tell us their name, contact details (if not given above) and their relationship to the child

Previous Address:	Previous GP & Address:

Health History

Has your child had any serious illnesses or operations?	**Yes** ☐ **No** ☐ (please tick)
If Yes, what was this and when? :	
Does your child have a disability or chronic condition?	**Yes** ☐ **No** ☐ (please tick)
If Yes, please give details and any reasonable adjustments needed:	

Medication

Is your child on any regular medication?	**Yes** ☐ **No** ☐ (please tick)
If Yes, please tell us the name and dose: (if you have a list from your previous GP please give us a copy) (Please note you may be need to see the doctor for a first repeat prescription to be issued)	
Is your child allergic to any medication?	**YES** ☐ **NO** ☐ (please tick)
If Yes, please state type and name:	

Which school or nursery does your child attend?		
Does your child have contact with any of the following? *(if so please can you tell us their names)*		
Hospital specialist?	**YES** ☐ **NO** ☐	
Health visitor?	**YES** ☐ **NO** ☐	
Social worker?	**YES** ☐ **NO** ☐	
Other Health Professionals?	**YES** ☐ **NO** ☐	
Has your child ever been under a Child Protection Plan?		**YES** ☐ **NO** ☐ (please tick)

Is your child on an early help plan?	**YES** ☐ **NO** ☐ (please tick)
If Yes, who is the co-ordinator?	
Is this child a looked after child? Eg in foster care	**YES** ☐ **NO** ☐ (please tick)

It is important that your child's immunisations are kept up to date. A current photocopy of the immunisation history will help us to maintain their immunisation record; we can take a photocopy of this at reception. If this is not available then please list below.

Immunisations		**Date given**
1st Diphtheria, Tetanus, Whooping Cough, Polio, Hib , rotavirus*	age 2m	
2nd Diphtheria, Tetanus, Whooping Cough, Polio, Hib, rotavirus*	age 3m	
3rd Diphtheria, Tetanus, Whooping Cough, Polio, Hib	age 4m	
1st Pneumococcal	age 2m	
2nd Pneumococcal	age 4m	
1st Meningitis C	age 3m	
Hib/ Meningitis C		
1st Measles, Mumps, Rubella (MMR)	age 12-13m	
Booster Pneumococcal		
Booster Diphtheria, Tetanus, Whooping Cough, Polio	age 3y 4m	
Booster Measles, Mumps, Rubella (MMR)		
Details of any other immunisations:		

***** *rotavirus included since 2012*

Thank you for completing this questionnaire.

For practice use only

Patient NHS number	Practice computer ID number	
Health Professionals informed		
Authorised by		Date