JS Medical Practice

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CONFIDENTIAL HEALTH QUESTIONNAIRE – CHILD

PLEASE COMPLETE FULLY

OFFICE USE ONLY

Receptionist initials: POA/ID: Yes No

GMS1 Check: - NHS Number ☐
- Previous GP ☐
- Town/Country of birth ☐
- Date of entry in UK ☐
- Sign and Date ☐
- Interpreter ☐

New Patient Check

Appt with **HCA/Practice Nurse/Sharon**

Date:..................... **Time:** ....

JS Medical Practice does not discriminate on the grounds of:

- Race, gender, social class, age, religion, sexual orientation or appearance
- Disability or medical condition

Please take the time to fill in this questionnaire so that we can provide you with the best service. Once completed please return to the JS Medical Practice reception.

Child's/Baby's Name: .... D.O.B.:..

Address: .... Home Tel:.....................................

....

Post code:..

Name and number of parent/carer to contact in an emergency: ....…………………………………………………

Sex: Male ☐ Female ☐

Mother's name: …………………………......................... Phone number ……………………………………………..

Father's name…………………………………………… …….Phone number…………………………………………...

Carer's/Foster parent's name if applicable………………………………………………………………………………

Name and number of SOCIAL WORKER if applicable……………………………………………………………….

Home status:

Please state whom this child/baby is living with …………………………………………………………………………….

Ethnicity:

Please state your child's/baby's ethnicity, e.g. White British; Black British; Asian Indian; White Polish;

....

Languages spoken (if applicable)..: ....

School name (if applicable) …….……………………………………………………………………………..

Personal and family history (If child old enough)

What is your child's height? .... Weight? ....

Please tick if you consent to receiving text messages (such as reminders) from the surgery for your child:

☐

Please tick if you wish to sign your child up for the online patient access services (appts & prescriptions):

☐

Does your **child/baby** have any of the following? If "yes" please tick in the box below and state the approximate date of diagnosis

Has any of your child's/baby's close **family** (mother, father, brother, sister, grandparent, uncle or aunt) suffered any of the following? If "yes" please tick in the box below

	Child (when/year of onset)	**Family member** (Who)
Asthma		
Type 1 Diabetes		
Epilepsy		

Medications

Please list any medications that your child/baby takes regularly:

....

....

Allergies

List any allergies to medications that your child/baby has (Please list below)

....

Immunisations

Is your child/baby up to date with their immunisations? Yes ☐..No ☐

Do you consent for your child/baby to have their immunisations? Yes ☐................................No ☐

If No please sign here that you do not consent for your child/baby to be immunised ………………………..

Reason?..

Thank you for completing the questionnaire. All information will be dealt with in the strictest confidence.

Please sign …………………………………………….. Date ………………………………………