Phyiscal

What is the child's height? cm

What is the child's weight? kg

Carers

Do you have a carer? Y N

Carer's Name

Carer's Address

Carer's Contact Tel

Are you a carer? Y N

If you would like to receive a resource pack please tick here

If yes for either, please give details

Signature

Date

DD / MM / YYYY

Office Use Only

Information Services Form received Y N

Chronic disease Y N

Appointment booked Y N

Date / / Time

Child on current medication Y N

Appointment booked Y N

Date / / Time

If none of the above, patient offered an appointment Y N

Appointment booked Y N

Date / / Time

Carers Resource Pack provided Y N

Named GP

Informed of Named GP

Checked by Sue W Sue E Sally Jo

St Georges Medical Centre

New Patient Questionnaire

Under 16s

Child's Details

Title

Surname

First name(s)

Date of Birth DD / MM / YYYY

School

Child's Ethnicity

- White British
- Other White background
- Irish
- Other Asian background
- Black African
- Other Mixed background
- Asian or Asian British
- Not stated
- Mixed White and Black Caribbean
- White and Asian
- White and Black African
- Black or Black British
- Chinese
- Black Caribbean Other Black background
- Indian Bangladeshi
- Other

Spoken Language

Religion

Parent & Guardian Details

	Parent / Guardian 1	Parent / Guardian 2
Name		
Relationship		
Home Tel		
Mobile Tel		
Address		

Communication Needs

At St George's Medical Centre, we want to make sure that we are communicating with you in a way that is easy for you and that you can understand:

- We want to know if you need information in a specific format e.g. braille, large print or easy read
- We want to know if you need to receive information in a particular way e.g. electronically, via email, for use with a screen reader
- We want to know if you need someone to support you at appointments e.g. a sign language interpreter or an advocate
- We want to know if you lipread or use a hearing aid or communication tool

Do you have any information or communication needs? Y ☐ N ☐

If so, how can we address these needs when communicating with you?

Medical History

Please list any serious illnesses / operations / accidents / disabilities and the year they took place:

Please list any medication the child takes at the moment:

Is the child allergic to any medicines? If so, which ones?

Medical History (cont.)

Has the child ever suffered from: (tick as appropriate)

☐ Eczema / Hay fever ☐ Diabetes ☐ High blood pressure

☐ COPD ☐ Cancer ☐ Depression

☐ Heart Attack / Stroke ☐ Asthma

	Y	N
Is the child registered disabled?	☐	☐
Is the child registered blind?	☐	☐
Is the child registered partially sighted?	☐	☐

Family History

Does the child have a family history of . . . (tick as appropriate)

☐ CVA ☐ Hypertension

☐ High blood fat ☐ CKD

☐ DVT/Thrombosis ☐ Diabetes

☐ Asthma ☐ Osteoporosis

☐ Glaucoma ☐ Breast Cancer

Any others, please state:

Smoking (over 14s)

Do you smoke? Y ☐ N ☐

If 'No', have you ever smoked? Y ☐ N ☐

Would you like advice on giving up smoking? Y ☐ N ☐

If you do currently smoke, how many cigarettes or ounces of tobacco do you smoke per day?