**Drs Jasper, Cockell, Jaitly, Hammill, Galayia, Akindele, Patel, Landymore**

**Farley Road Medical Practice**

**NEW PATIENT QUESTIONNAIRE (Under age 14)**

**Please complete in CAPITAL LETTERS\* These details are mandatory**

**\*** First name(s)…………………………………………………………………………………………………………..

\* Surname……………………………………………………………………………………………………………….

**\*** Sex Male  Female  **\*** Date of Birth……………………………………………………………………

**\*** Address………………………………………………………………………………………………………………..  
  
 ………………………………………………………..….Post Code……………………………………..…………..

**\*** Contact telephone number:   
Home……………………………………….…………….Mobile……………………………………………………..

**\*** Parent/Guardians Name…………………………………………………………………………………………….

Carers name (if applicable)…………….…………………………………………………………………………….

\* Please circle/tick one description below which best describes the child’s ethnicity

|  |  |  |
| --- | --- | --- |
| White | White British |  |
|  | White Irish |  |
|  | Any Other White Ethnic Group |  |
| **Mixed** | White & Black Caribbean |  |
|  | White & Black African |  |
|  | White & Asian |  |
|  | Any other Mixed background |  |
| **Asian or Asian British** | Indian |  |
|  | Pakistani |  |
|  | Bangladeshi |  |
|  | Sri Lankan |  |
|  | Any other Asian background |  |
| **Black or Black British** | Caribbean |  |
|  | African |  |
|  | Any other Black background |  |
| **Other Ethnic Group** | Chinese |  |
|  | Any other Ethnic group |  |

**First Spoken Language ……………………………………………………………**

**\***  Do You Smoke? Yes  No  If **YES** How many cigarettes per day?.........................

# \* Height & Weight

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Height: |  | Weight: |  | Waist: |  |

Please be as accurate as possible

**IMMUNISATIONS**

Please indicate which immunisations the child has had. The exact dates they were carried out and whether they were done at the previous doctor’s surgery, a health authority clinic or elsewhere.

Details can be found in the back of the red Child Development book.

|  |  |  |  |
| --- | --- | --- | --- |
| IMMUNISATION | Date | G.P | Clinic |
| 1st Diptheria, tetanus, polio |  |  |  |
| 1st Whooping cough |  |  |  |
| 1st HIB |  |  |  |
| 1st Meningitis C |  |  |  |
| 2nd Diptheria tetanus, polio |  |  |  |
| 2nd Whooping cough |  |  |  |
| 2nd HIB |  |  |  |
| 2nd Meningitis C |  |  |  |
| 3rd Diptheria, tetanus, polio |  |  |  |
| Pneumococcal |  |  |  |
| 3rd Whooping cough |  |  |  |
| 3rd HIB |  |  |  |
| 3rd Meningitis C |  |  |  |
| Measles, mumps, rubella (MMR) |  |  |  |
| Pre-school booster |  |  |  |
| MMR booster |  |  |  |

**CHILDHOOD ILLNESSES**

**Has the child had any of the following illnesses?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Asthma | Yes No | Hay Fever | Yes No | Chicken pox | Yes No |
| Measles | Yes No | Diabetes | Yes No | Kidney problem/cystitis | Yes No |
| Mumps | Yes No | Heart disease/murmur | Yes No | Epilepsy/fits | Yes No |
| German Measles | Yes No | Eczema | Yes No | Tumours | Yes No |
| Physical Handicap | Yes No | Mental Handicap | Yes No |

Please list any hospital admissions, with the reason and (approximate) date(s): ……………………………….  
……………………………………………………………………………………………………………………………..………………………………………………………………………………………………….....................................

Has the child attended any hospital outpatient clinics, or is he/she currently attending such a clinic? Please give details: ..............................................……………………………………………………………………………

…………………………………………………………………………………………………………………………….

…………………………………………………………………………………………………………………………….

**MEDICATION**

Please list any **REPEAT** prescribed medication the child is taking:………………………………………………  
……………………………………………………………………………………………………………………………  
……………………………………………………………………………………………………………………………

Is he/she **ALLERGIC** to any medicines? Yes  No

If Yes please give details:…………………………………………………………………………………………….  
……………………………………………………………………………………………………………………………..

January 2015