Rosemary Surgery, 2 Rosemary Avenue,
London N3 2QN

NEW PATIENT HEALTH QUESTIONNAIRE

(FOR CHILDREN UP TO 16YEARS)

OFFICE USE ONLY Please tick date and initial
Photo ID seen:
Document Type (Proof of Address):
Initials: Date:

In order to be fully registered with this practice, this form MUST be completed by the parent/guardian with the child's details.

TITLE:		**FIRST NAME:**	
SURNAME:		**CURRENT SURNAME:**	
		PREVIOUS SURNAME:	
ADDRESS:		**WHO ELSE LIVES IN THIS HOUSEHOLD?** (please tick all those that apply)	
Postcode:		☐ Mum ☐ Dad ☐ Step parent ☐ Grandparents ☐ Sibling How many ☐ Foster care ☐ Guardian ☐ Others Please state	
HOME TEL:		**MOBILE TEL:**	
EMAIL ADDRESS:			
WHO DO THESE DETAILS BELONG TO? (e.g. mum, dad etc.)		**EMAIL:**	
		HOME:	
		MOBILE:	
CAN WE LEAVE MESSAGES REGARDING YOUR CHILD ON THESE NUMBERS?		**MOBILE:**	☐ **YES** ☐ **NO**
		HOME:	☐ **YES** ☐ **NO**
Would you like to register with the practice for SMS text messages reminders?		☐ **Yes** ☐ **No**	
WHO HAS PARENTAL RESPONSILITY FOR THIS CHILD? Please tell us their name, contact details (if not given above) and their relationship to the child			
PREVIOUS ADDRESS:		**PREVIOUS GP'S NAME & ADDRESS:**	

Thank you for completing this form.

Rosemary Surgery, 2 Rosemary Avenue,
London N3 2QN

HEALTH HISTORY	
HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES OR OPERATIONS?	☐ **YES** ☐ **NO**
If Yes, what was this and when?	
DOES YOUR CHILD HAVE A DISABILTY OR CHRONIC CONDITION?	☐ **YES** ☐ **NO**
MEDICATION	
IS YOUR CHILD ON ANY REGULAR MEDICATION?	☐ **YES** ☐ **NO**
If Yes, please state type and dose: (if you have a list from your previous GP please give us a copy) **(please note you may need to see doctor for a first repeat prescription to be issued)**	
IS YOUR CHILD ALLERGIC TO ANY MEDICATION?	☐ **YES** ☐ **NO**
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)	
A hospital specialist? YES ☐ NO ☐ **A Health Visitor? YES ☐ NO ☐** **A social worker? YES ☐ NO ☐** **Any other Health Professional? YES ☐ NO ☐**	
Has your child ever been under a Child Protection Plan?	☐ **Yes** ☐ **No**

Thank you for completing this form.

Rosemary Surgery, 2 Rosemary Avenue,
London N3 2QN

Additional Immunisations:	

ETHINICITY (Please tick ☐ a box)

White British ☐	**Bangladeshi/British Bangladeshi ☐**
White Irish ☐	**Other Asian Background ☐**
Other White Background ☐	**Black or Black British Caribbean ☐**
White and Black Caribbean☐	**Black or Black British African ☐**
White and Black African ☐	**Any Other Black British African ☐**
White and Asian ☐	**Chinese ☐**
Other mixed background ☐	**Other Ethnic Category ☐**
Indian/British Indian ☐	**I do not Wish to State my Ethnicity ☐**
Pakistani/British Pakistani ☐	

What is your Main Language?

Do you need an interpreter or sign language support? Yes ☐ No ☐

Please give the name and location of the chemist you would like your prescriptions to be sent electronically:

PLEASE COMPLETE EVEN IF YOU ARE NOT TAKING REGULAR MEDICATION

IMPORTANT:

All the information given to the practice as part of this form will be treated as Confidential. However to give your child the very best health care we work closely with the Health Visiting and School Nursing Service. It is therefore our normal practice to share the details of the children registering with the Practice with our NHS colleagues in Health visiting and School nursing.

If you would prefer that we DO NOT do this could you tick here ☐

Thank you for completing this form.

Rosemary Surgery, 2 Rosemary Avenue,
London N3 2QN

It is important that your child's immunisations are kept up to date. Has this child had the following immunisations?

Primary Immunisations 1st	**Date Immunised**	
Diptheria, Tetanus, Whooping Cough, Polio, Haemophilus Influenza type b	**DTaP/IPV/Hib**	
OR		
Diptheria, Tetanus, Whooping Cough, Polio, Haemophilus Influenza type b, Hepatitis B	**DTaP/IPV/Hib/HepB**	
Meningitis B	**MenB**	
Rotavirus	**Rota**	
Primary Immunisations 2nd	**Date Immunised**	
Diptheria, Tetanus, Whooping Cough, Polio, Haemophilus Influenza type b	**DTaP/IPV/Hib**	
OR		
Diptheria, Tetanus, Whooping Cough, Polio, Haemophilus Influenza type b, Hepatitis B	**DTaP/IPV/Hib/HepB**	
Pneumococcal	**PCV**	
Rotavirus	**Rota**	
Primary Immunisations 3rd	**Date Immunised**	
Diptheria, Tetanus, Whooping Cough, Polio, Haemophilus Influenza type b	**DTaP/IPV/Hib**	
OR		
Diptheria, Tetanus, Whooping Cough, Polio, Haemophilus Influenza type b, Hepatitis B	**DTaP/IPV/Hib/HepB**	
Meningitis B	**MenB**	
12 – 13 Month Immunisations		
Haemophilus Influenzae type b, Meningitis C	**Hib/MenC**	
Pneumococcal	**PCV**	
Measles, Mumps, Rubella	**MMR**	
Meningitis B	**MenB**	
Pre – School Booster Immunisations		
Diptheria, Tetanus, Whooping Cough, Polio	**DTaP/IPV or DTaP/IPV**	
Measles, Mumps, Rubella	**MMR**	
Teenage Booster Immunisations		
Diptheria, Tetanus, Polio	**Td/IPV**	
Meningitis ACWY	**MenACWY**	
HPV Immunisations		
Ist Immunisation	**HPV**	
2nd Immunisation	**HPV**	

Thank you for completing this form.