New Patient Questionnaire
For Children and Young Persons Under 16

This information that we request on this form is to help us offer you the best advice and treatment that we can.
Please complete all the questions

Details of Child				
Surname				
Forenames				
Date of Birth			Male	Female
NHS No				
Address				
Town + Postcode				
First language of child				
Ethnicity *Please circle* If other ethnicity, please enter in space provided	White British	White Irish	White/other	White traveller
	Black African	Black	White/Black	White/Black
	Other Black	Pakistani	Bangladeshi	Indian
	Chinese	Arab	Other Asian	Mixed ethnicity
	Polish	Romanian	Latvian	Other Baltic
Nationality				
Place of birth				
Details of Main Carer				
Full name of main carer				
Address				
Town - Postcode				
Contact telephone numbers	Home	Mobile	Work	
Relationship to Child				
First language of carer				
Next of Kin (if different)				
Relationship to Child				
Address				

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Contact telephone numbers	Home	Mobile	Work
Social History			
Name of school or nursery			
Name of Previous GP			
Address of previous GP surgery			
Social worker involved?			
Looked after child?	Fostered	Residential	Asylum seeker
Medical History			
Birth history	Birth weight =	Premature delivery?	Type of delivery
Problems after delivery?			
Developmental conditions e.g. Autism or ADHD or mental health problems			
Medical conditions	Asthma	Diabetes	Thyroid disease
Note any other conditions not listed in the next section	Hypertension	Epilepsy	Heart disease
Operations or other important conditions or illnesses			
Medication	Drug allergies...		
1			
2			
3			

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the meadows

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4			
Other allergies			
Family History	Only tick if these apply to first degree relatives i.e. parents and siblings		
Asthma	Diabetes	Heart disease	Epilepsy
Eyesight problems	Early hearing loss	Cancer…enter type =>	
Immunisations (please circle)	Are your immunisations up to date? Yes No		
	If born overseas please provide immunisation history		
Household member with	Tuberculosis	Hepatitis	HIV
Other infection (give details)			

PRACTICE USE ONLY		
Vaccination status required? *Please circle*	Yes If yes, please get evidence	No
Staff Name		
Date Form Taken in		