# Please complete ALL questions BABY 0-4 years

# New Patient Questionnaire

**Welcome to Prestbury Medical Practice**

It is important that we have your **correct Name and Address**, so that we can operate an efficient filing system. We would be grateful if you would take the time to complete the form below as fully as you can.

If in the future any of these details change, please let us know.

**The questionnaire NEEDS to be completed in full before registration can go ahead.**

Surname…………………………………………………………………………………...

Forename (s)…………………………………………………………………………....

Date of Birth: ………… / ……………... / …………….

Preferred contact preference:

Please circle one or more EMAIL □ TELEPHONE □ TEXT MESSAGE □

Ethnic Origin: (Please tick appropriate)

British □ Irish  □

White & Black Caribbean □ White & Black African □

White & Asian □ Indian □

Pakistani □ Caribbean □

African □ Chinese □

Bangladeshi □ Other □

Not wishing to give information □

If other please state……………………………………………………………….

Main Language: (Please tick appropriate)

English □ Polish □ Hindi □

Punjabi □ German □ Italian □

Urdu □ Thai □ Czech □

British sign language □

Not wishing to give information □

If other please state……………………………………………………………….

Do you require an interpreter YES □ NO □

If you have given Birth to a twin or Multiples, please Circle who was born first – I.E Twin 1 / Twin 2 - Etc…….

Twin 1 Twin 2 Multiples 1 / 2 / 3

Birth Height………………………. Birth Weight………………………

(1) Was your child born full term? YES / NO

If no can you tick the appropriate box below.

Child born between:

 24 – 26 weeks □

 27 – 28 weeks □

 29 – 32 weeks □

 33 – 36 weeks □

 37 – 38 weeks □

1. Type of delivery, (Please ticks the appropriate box)

Elective Caesarean Delivery □

Emergency Caesarean Delivery □

Vaginal Delivery □

Vaginal Forceps Delivery □

Vaginal Ventouse Delivery □

1. Type of feeding - Breast Fed □ Bottle Fed □ Both □
2. Any relevant family history? E.g. diabetes, asthma etc

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

 IMPORTANT - Please give details of Next of Kin

Name: ……………………………………………………………………………………………………...

Address: …………………………………………………………………………………………………...

Relationship: …………………………………………………………………………………………...

Signature: ……………………………………………………………………………………………….

 IMPORTANT- Please give details if you are Carer/Legal Guardian

 Name………………………………………………………………………………………………………………

 Address…………………………………………………………………………………………………………...

 Telephone Number…………………………………………………………………………………………...

 Relationship……………………………………………………………………………………………………...

 Signature………………………………………………………………………………….

**PATIENTS CURENT CONSENT PREFERENCE**

(IMPLIED CONSENT FOR MEDICATION, ALLERGIES AND ADVERSE REACTIONS -SHARE WITH OTHER HEALTH PROFESSIONALS eg out of hours)

Please select one option only

|  |
| --- |
|  |

1. EXPRESS CONSENT FOR MEDICATION, ALLERGIES AND ADVERSE REACTIONS

ONLY

1. EXPRESS CONSENT FOR MEDICATION, ALLERGIES AND ADVERSE REACTION AND

ADDITIONAL INFORMATION

|  |
| --- |
|  |

1. EXPRESS DISSENT (OPT OUT) – YOU DO NOT WANT A SUMMARY CARE RECORD

|  |
| --- |
|  |

Signature of/on behalf of patient…………………………………………………………………………………………………………………..

Date………………………………………………………………………………………………………………………

**PROXY CONSENT FORM**

**[to access details on behalf of the patient-up to 16yrs of age]**

|  |  |
| --- | --- |
| Patient Details  | PROXY Details |
| Name: | Name: |
| Address: | Address: |
| Post Code: | **Post code:** |
| Telephone: |  |
| Email (Mandatory): |  |
| Mobile: |  |
| Date of Birth: | **Date of birth:**  |

I give permission the above named to have access to my medical records and personal details held by the Practice via the Online Services – Patient Access.

I the patient wish the above named to have access to: Tick all that apply.

|  |  |
| --- | --- |
| 1. Online appointment booking
 |  |
| 1. Online prescription management
 |  |
| 1. Access to my medical record
 |  |

I understand that this consent will remain in force indefinitely. However, my doctor may, at my request, override this authority to allow access to my medical records via the Patient Access/Online Services at any time. I understand the risks of allowing someone else to have access to my medical records.

I will treat any information provided confidentially, I will not disclose information to a third party without agreement and will only use the information in the person that I have proxy access for in their best interest.

**Signed**.............................................................................. Parent/Guardian

Date..................................................................................

**STAFF ONLY – Form passed for scanning onto patient record initial and date**

**Name…………………………………………………**

**Date…………………………………………………...**