Millcroft Medical Centre

**Eagle Bridge Health & Wellbeing Centre**

**Dunwoody Way, Crewe**

**Cheshire, CW1 3AW**

**Telephone**: (01270) 275200 (all enquiries) **Cancellations** : (01270) 275199

**Website** : [www.millcroftmedicalcentre.nhs.uk](http://www.millcroftmedicalcentre.nhs.uk)

**New Patient Health Questionnaire For Under 16’s**

**Your Contact Details**

|  |  |
| --- | --- |
| Title: | D.O.B: |
| Full Name: | NHS Number: |
| Home Address:Home Tel No: Mobile Number: Place of Birth:  | Email Address |
|  Your prescription will be sent via our Electronic Prescribing Service (information available at reception) please nominate your pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If you were **NOT** born in the UK, what was the date you came to live in the UK:  |

**Were you ever registered with an Armed Forces GP**

|  |
| --- |
| Please indicate if you have served in the UK Armed Forces and/or been registered with a Ministry of Defence GP in the UK or overseas:  |
| [ ]  Regular [ ]  Reservist [ ]  Veteran [ ]  Family Member (Spouse, Civil Partner, Service Child)Address before enlisting:Service or Personal number: Enlisting date: Discharge date Footnote: These questions are optional, and your answers will not affect your entitlement to register or receive services from the NHS but may improve access to some NHS priority and service charities services. |

**Information about You**

|  |  |  |
| --- | --- | --- |
| Height:  | Weight: | Main Language: |

**Ethnic Background**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **White:**  | [ ]  British  | [ ]  Irish | [ ]  Other |  |
| **Black:** | [ ]  Caribbean | [ ]  African | [ ]  Other |  |
| **Asian:**  | [ ]  Indian  | [ ]  Pakistan | [ ]  Chinese | [ ]  Other |
| **Mixed:**  | [ ]  White and Black Caribbean | [ ]  White and Black African | [ ]  White and Asian | [ ]  Other |
| What is your main spoken language? |
| Do you require an interpreter? [ ] Yes [ ]  NoIf Yes what language:Are you an Asylum Seeker? [ ] Yes [ ]  No(Answering this question will not affect your registration with the practice) |

**Parent/Carer Details**

|  |
| --- |
| Name:Address:Tel No:Relationship to Child:  |

**Previous Address:**

|  |  |
| --- | --- |
| Name: | Address: |

**Previous GP Details:**

|  |  |
| --- | --- |
| Name: | Address: |

**Information or communication needs**

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| --- |
| What is your preferred communication method? |
| [ ]  Letter to Home Address[ ]  Email Address | [ ]  Telephone call[ ]  Any communication method | [ ]  SMS text message |
| Do you suffer from impaired vision? [ ]  Yes [ ]  NoIf yes, would you prefer to receive communication in a different way? [ ]  Yes, please specify ……………………………………………………… [ ]  No |
| Signature of / on behalf of Patient: Date:  |

**Childhood Immunisations (please note any additional forms with information we kindly ask to be translated to English where possible.)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Immunisations**  | **Stage 1**Date given | **Stage 2**Date given | **Stage 3**Date given | **Booster**Date given |
| **Diptheria/Tetanus** |  |  |  |  |
| **Pertussis** |  |  |  |  |
| **Polio** |  |  |  |  |
| **HIB** |  |  |  |  |
| **Hepatitis B** |  |  |  |  |
| **Pneumococcal** |  |  |  |  |
| **Measles/Mumps/Rubella** |  |  |  |  |
| **BCG** |  |  |  |  |
| **Meningitis B** |  |  |  |  |
| **Meningitis C** |  |  |  |  |
| **Rotavirus** |  |  |  |  |
| **Any Others – Please specify** |  |  |  |  |

**Medical Information**

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| --- |
| We need to know of any medical problems you may have or have had so we can provide better care for our patients. Please answer all the questions below with as much detail as you can. Have you ever suffered from any of the following? |
| [ ]  Epilepsy  | [ ]  Asthma  | [ ]  Bipolar |
| [ ]  High Blood Pressure  | [ ]  Eczema | [ ]  Glaucoma  |
| [ ]  Heart Attack  | [ ]  Blindness | [ ]  COPD  |
| [ ]  Depression:  | [ ]  Diabetes  | [ ]  Hay Fever  |
| [ ]  OCD:  | [ ]  Stroke  |   |
| [ ]  Cancer:  | [ ]  Anxiety |  |
| Are you on any long-term treatment or medications from any other services? Please detail below:  |
| Please list any operations, accidents, disabilities, problems in pregnancy or illnesses and the year they took place if not previously mentioned.  |
| Are you registered disabled? [ ]  Yes [ ]  NoIf yes please give details  |
| Are you allergic to any medications? [ ]  Yes [ ]  NoIf yes please give details |
| Have you ever refused treatments or screening of any kind? [ ]  Yes [ ]  NoIf yes please give details |
| Have you ever suffered from any other mental health illnesses? [ ]  Yes [ ]  No If yes please give details |
| Please list all medication that you are currently taking along with Dose and Frequency |

**Family History**

|  |
| --- |
| Has anyone in your family had any serious illnesses such as:  |
| [ ]  Cancer | Relation:  | Type: |
| [ ]  Heart Disease | Relation: |
| [ ]  Stroke | Relation: |
| [ ]  High Blood Pressure | Relation: |
| [ ]  Diabetes | Relation: | Type: |
| [ ]  Other Inherent illness | Relation:  | Illness: |
| Have you ever had a Flu Vaccination? [ ]  Yes [ ]  No If yes please provide a date:Have you ever had a Pneumococcal Vaccination? [ ]  Yes [ ]  NoIf yes please provide a date: |

Summary Care Record Data is uploaded from your GP practice to create your Summary Care Record (SCR). Your SCR contains important information about your medication, allergies and reactions to medicines that you have had. This information can then be used when caring for you in an emergency, when your GP practice is closed or when you are away from home elsewhere in England. Your Summary Care Record will also include your name, address, date of birth and your unique NHS Number to help identify you correctly. You may want to add other details about your care to your Summary Care Record eventually. Healthcare staff will ask your permission every time they need to look at your Summary Care Record. If they cannot ask you, eg. if you are unconscious, healthcare staff may look at your record without asking you. If they have to do this, they must record the reason on your record

**I DO NOT** wish to share my medical record for the purpose identified above

|  |  |
| --- | --- |
| **Sign:** | **Date:** |

If you are filling out this form on behalf of another person or child, please ensure you fill out their details above and your details below

|  |  |
| --- | --- |
| **Sign:** | **Date:** |