EM Eric Moore Partnership Medical Practice

CHILD NEW PATIENT REGISTRATION QUESTIONNAIRE & ASSESSMENT

SECTION TO BE COMPLETED BY PATIENT			
FULL NAME		DATE OF BIRTH	
ADDRESS			
HOME PHONE №		MOBILE №	
EMAIL ADDRESS			
ETHNICITY		MAIN SPOKEN LANGUAGE	
ALL PERSONS WITH PARENTAL RESPONSIBILITY		SCHOOL/COLLEGE (IF APPLICABLE)	

ARE YOU RECEIVING TREATMENT FOR ANY ONGOING MEDICAL CONDITIONS, AND / OR HAVE YOU HAD ANY MAJOR OPERATIONS?	YES / NO (Please list conditions and medications prescribed) 1 2 3 4 5 6 7
IF YOU CURRENTLY RECEIVE ONGOING MEDICATION WE WILL NEED TO SEE EVIDENCE OF THIS (printed prescription from previous GP or labelled box) IN ORDER TO RE-ISSUE YOUR MEDICATION	
IS THERE ANY FAMILY HISTORY OF MEDICAL CONDITIONS SUCH AS HEART, DIABETES, RESPIRATORY, STROKE OR CANCERS?	YES / NO (Please give details of condition, relationship to family member and age of relative at time of diagnosis)
DO YOU SUFFER FROM ANY ALLERGIES?	YES / NO (Please give details)

HEIGHT (approx value if unsure)		WEIGHT (approx value if unsure)	
DO YOU DRINK ALCOHOL?	YES / NO	If you do drink alcohol, please answer the questions below	
How often do you have a drink containing alcohol?			
How many units of alcohol do you drink on a typical day when drinking?			
On how many occasions have you drank 6 units (female) or 8 units (male) in the last year?			
DO YOU SMOKE TOBACCO?	YES / NO	DAILY TOBACCO USAGE	
If you currently smoke tobacco and would like to talk to someone about stopping smoking, please ask at the surgery about the free services which are available to you. If you do not wish to stop smoking please mark box ☐			

WOULD YOU CLASS YOUR PHYSICAL ACTIVITY AS: (please circle)	VERY ACTIVE	MODERATE	INACTIVE
WOULD YOU CLASS YOUR DIET AS: (please circle)	GOOD	MODERATE	POOR
DO YOU NEED HELP IN ORDER TO CARE FOR YOURSELF?	YES / NO	Name of Carer if yes:	
DO YOU PROVIDE CARE FOR A DISABLED PERSON?	YES / NO		

By signing below I confirm that, to the best of my knowledge, the statements made on this document are true, full and correct. I acknowledge that clinicians will base their advice and treatment on these statements. I accept that non-disclosure of relevant information will render this application void and I will not be accepted onto the practice list, or will subsequently be removed from the practice list.

SIGNED (PATIENT) if form completed by child		DATE	
SIGNED (PARENT/GUARDIAN) if form completed by parent / guardian		DATE	

We use SMS services to remind patients about appointments due and booked. To opt-out please mark box ☐