**NEW PATIENT QUESTIONNAIRE - <16 years old**

**Please complete the following in CAPITAL letters and tick the boxes where necessary**

**FIRST NAMES:** …………………………………………………………………………

**SURNAME:** …………………………………………………………………………………

**DATE OF BIRTH (DD/MM/YY):** ………………………………………………

**Ethnic Origin : Please tick**

Bangladeshi Other ethnic origin

Black African Other mixed origin ethnic

Black British Other white ethnic

Black Caribbean Pakistan

Black, other White British

Chinese White Irish

Indian White Scottish

Other Asian

**NAME OF PARENTS/GUARDIANS:** ……………………………………...............................................................…………………

**PREVIOUS MEDICAL HISTORY and DATES:**

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

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

**IS THE CHILD ON ANY CURRENT MEDICATION? YES NO**

***If yes please list below:***

**DOES THE CHILD HAVE ANY DRUG OR NON DRUG ALLERGIES? YES NO**

**IF YES, PLEASE SPECIFY.**

**Have you provided a repeat order form from your previous surgery yes / no**

**Please circle which chemist you would like to collect your prescription from?**

**Boots KinWell Ardersier Pharmacy Tornagrain**

…………………………………………………………………………………………………………………………………………………………………………………

**Has the child had their HPV vaccine? YES / NO**

**If so when?**

|  |  |
| --- | --- |
| **Dose** | **Date Given** |
| **1st** |  |
| **2nd** |  |
| **3rd if applicable** |  |

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

**FOR UNDER 5 YEAR OLDS ONLY:** IMMUNISATION HISTORY -or provide copy of Red Book

|  |  |  |
| --- | --- | --- |
| **TYPE** | **DOSE** | **Date Given** |
| DTaP / IPV / Hib /Hep B | 1ST DOSE2ND DOSE3RD DOSE |  |
| DTaP/IPV | 4THDOSE/BOOSTER |  |
| Pneumococcal (PCV) | 1ST DOSE2ND DOSE3RD DOSE |  |
| Meningitis C  | 1ST DOSE2ND DOSE |  |
| Meningitis B | 1ST DOSE2ND DOSE3rd DOSE |  |
| MMR  | 1ST DOSE2ND DOSE |  |
| Rotavirus | 1ST DOSE2ND DOSE |  |
| HiB/MenC |  |  |
| Flu Vaccine |  |  |
| **OTHER e.g. HepB, BCG etc (Please list below) :** |  |  |

**OFFICE USE ONLY**

**IMMUNISATION DETAILS LOGGED** NAME: DATE: