Gade Surgery

NEW PATIENT HEALTH QUESTIONNAIRE (FOR CHILDREN UP TO 16Y)

Please complete all sections of this booklet in BLOCK CAPITALS then return it to reception with the following document to confirm details, originals please (if you are also able to bring a set of copies it will save you time)

Birth Certificate Seen:	Initials:	Date:	FORM GMS 1

Patient's details

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname .....

Date of birth ___ /___ / _____

First names .....

NHS no _____ / _____ / _____

Previous surname/s .....

☐ Male ☐ Female

Town & country of birth .....

Home address .....

.....

Postcode..... Telephone number .....

Mobile Telephone No.. ..... (*By providing us with your mobile number, you consent to the Practice contacting you by mobile telephone which may include texting reminders of appointments.)*

Please tick if you are: ☐ Currently in the Armed Forces ☐ A Military Veteran
☐ The Dependant of a serving member of the Armed Forces

Please help us trace your previous medical records by providing the following information :

Your previous address in UK

.....

.....

Name of previous doctor/surgery whilst at that address

.....

.....

If you have come from abroad and have been registered with the NHS in the past :

Your previous address in UK

.....

.....

Name of previous doctor/surgery whilst at that address

.....

.....

Date you re-entered the UK .....

Date you left the UK .....

If you have come from abroad and have never been registered with the NHS in the past

Date you entered the UK .....

If you are registering with the NHS having recently left the Armed Forces :

Date of Enlisting **___/___/___** Date of Leaving **___/___/___** **Please supply a copy of your Discharge papers**

Address **before** enlisting .....

Name of previous doctor/surgery whilst at that address .....

Signature of Patient .....

Please print name if signed on behalf of the Patient ..... **Date___/___/___**

For Office use only: Patient has been informed of their named GP Yes / No

WHO HAS PARENTAL RESPONSIBILITY FOR THIS CHILD? Please tell us their name, contact details (if not given above) **and their relationship to the child**		
WHO ELSE LIVES IN THIS HOUSEHOLD ? (Please tick all those that apply)	Mum ☐ Dad ☐ Step parent ☐ Parent's partner ☐ Grandparents ☐ Brothers and sisters ☐ how many? ☐ Foster carer ☐ guardian ☐ Others- please state	
WHO DO THESE DETAILS BELONG TO ? (e.g. mum, dad etc.)	**EMAIL:**	
	HOME:	
	MOBILE:	
CAN WE LEAVE MESSAGES REGARDING	**MOBILE:**	**YES** ☐ **NO** ☐
	HOME:	**YES** ☐ **NO** ☐
Would you like to register with the Practice for SMS text message reminders ?		**YES** ☐ **NO** ☐

HEALTH HISTORY		
Your child's birth weight		
HAS YOUR CHILD HAD ANY SERIOUS ILLNESSES OR OPERATIONS?		
If Yes,what was this and when? :		**YES** ☐ **NO** ☐ (please tick)
DOES YOUR CHILD HAVE A DISABLITY OR CHRONIC CONDITION?		
		YES ☐ **NO** ☐ (please tick)

MEDICATION	
IS YOUR CHILD ON ANY REGULAR MEDICATION?	**YES** ☐ **NO** ☐ (please tick)
If Yes, please tell us the name and dose: (if you have a list from your previous GP please give us a copy) (Please note you may be need to see the doctor for a first repeat prescription to be issued)	
IS YOUR CHILD ALLERGIC TO ANY MEDICATION?	**YES** ☐ **NO** ☐ (please tick)
If Yes, please state type and name:	

Which school or nursery does your child attend?	
Does your child have contact with any of the following? *(if so please can you tell us their names)*	
A hospital specialist? **YES** ☐ **NO** ☐ (please tick) A health visitor? **YES** ☐ **NO** ☐ (please tick) A social worker? **YES** ☐ **NO** ☐ (please tick) Any other health professionals? **YES** ☐ **NO** ☐ (please tick)	
Has your child ever been under a Child Protection Plan?	**YES** ☐ **NO** ☐ (please tick)
Has your child ever been classified as a looked after child?	**YES** ☐ **NO** ☐ (please tick)

It is important that your child's immunisations are kept up to date. A current photocopy of the immunisation history will help us to maintain their immunisation record; If this is not available then please list below.

IMMUNISATIONS	**DATE GIVEN**
1st Diphtheria, Tetanus, Whooping Cough, Polio, Hib , *rotavirus** *age 2m*	
2nd Diphtheria, Tetanus, Whooping Cough, Polio, Hib, *rotavirus** *age 3m*	
3rd Diphtheria, Tetanus, Whooping Cough, Polio, Hib *age 4m*	
1st Pneumococcal *age 2m*	
2nd Pneumococcal *age 4m*	
1st Meningitis C *age 3m*	
Hib/ Meningitis C 1st Measles, Mumps, Rubella (MMR) *age 12-13m* Booster Pneumococcal	
Booster Diphtheria, Tetanus, Whooping Cough, Polio *age 3y 4m* Booster Measles, Mumps, Rubella (MMR)	
Details of any other immunisations:	

***** *rotavirus included since 2012*

IMPORTANT:

All the information given to the Practice as part of this form will be treated as Confidential.
However to give your child the very best health care we work closely with the Health Visiting and School Nursing Service.

It is therefore our normal Practice to share the details of all children registering with the Practice with our NHS colleagues in Health Visiting and School Nursing.
If you would prefer that we DO NOT do this could you tick here ☐

Please help us to assess the needs of our patient population and address any inequalities in access and health outcomes by providing us with the following information:

DO YOU HAVE ANY SPECIAL COMMUNICATION NEEDS?

For example sign language, lip reading, easy read or large print documents.
If YES, please let us know how you would like the Practice to communicate with you.

ETHNICITY

To which of these ethnic groups do you feel you belong? (please tick) *Ethnic groups defined by the Department of Health*

☐ White British	☐ Mixed White & Asian	☐ Bangladeshi/British
☐ Irish	☐ Other Mixed	☐ Other Asian
☐ Other White	☐ Chinese	☐ Caribbean
☐ Mixed White & Black Caribbean	☐ Indian / British	☐ African
☐ Mixed White & Black African	☐ Pakistani / British	☐ Other Black

Other (please specify) ……

If English is **not** your main spoken language please let us know what is _____

Do you need an interpreter? Yes No

NHS ORGAN DONOR REGISTRATION

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ All organs and tissue

Signature confirming consent to inclusion on the NHS Organ Donor Register Date ___ / ___ / _____

……

For more information, please ask at Reception for an information leaflet, or visit the website www.uktransplant.org.uk, or call 0300 123 23 23

NHS BLOOD DONOR REGISTRATION

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register Date ___ / ___ / _____

……

For more information, please ask for the leaflet on joining the NHS Blood Donor Register
My preferred address for donation is: (only if different from home address provided eg/your place of work)

…… Postcode ……

NEXT OF KIN / EMERGENCY CONTACT

We will record this information and may use it if we are unable to reach you in an emergency or need to make urgent contact with somebody on your behalf.

Name	Contact number	Relationship	Please indicate whether :	Can discuss your record?
			Next of Kin / Emergency Contact	Yes / No
			Next of Kin / Emergency Contact	Yes / No
			Next of Kin / Emergency Contact	Yes / No