



# Attleborough Surgeries

## Confidential Health Questionnaire

**New Patients Under 16**

**To be completed by a Parent or Guardian**

We welcome new patient registrations. Please complete this questionnaire (on behalf of your child) as fully as possible. The information will help the doctor to make an initial assessment of your child's health which will help in their future treatment. Please check the form carefully and give us as much information as you have available. Items marked with an asterisk (\*) are mandatory. Information will be treated as strictly confidential.

<b>Title*</b>	<input type="text"/>	<b>Surname*</b>	<input type="text"/>	<b>Date Of Birth*</b>	<input type="text"/>	/	<input type="text"/>	/	<input type="text"/>
<b>First Name(s)*</b>	<input type="text"/>								
<b>Previous Surnames(s)</b>	<input type="text"/>								
<b>Address*</b>	<input type="text"/>								
	<input type="text"/>								
	<input type="text"/>								
	<input type="text"/>								
<b>Home Tel.*</b>	<input type="text"/>								
<b>Post Code*</b>	<input type="text"/>								
<b>Town &amp; Country Of Birth</b>	<input type="text"/>								
<b>First Language</b>	<input type="text"/>								
	<b>Do they need an interpreter?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>								
<b>Ethnicity (Please tick the description you feel is most appropriate). If you do not wish to provide this, please tick Information Refused at the bottom of the list.</b>									
<b>White-British</b>	<input type="checkbox"/>	<b>White-Irish</b>	<input type="checkbox"/>						
<b>Other-White Background</b>	<input type="checkbox"/>	<b>Mixed-White and Black Caribbean</b>	<input type="checkbox"/>						
<b>Mixed-White and Black African</b>	<input type="checkbox"/>	<b>Mixed-White and Black Asian</b>	<input type="checkbox"/>						
<b>Other-Mixed Background</b>	<input type="checkbox"/>	<b>Asian or Asian British-Pakistani</b>	<input type="checkbox"/>						
<b>Asian or Asian British-Bangladeshi</b>	<input type="checkbox"/>	<b>Other Asian Background</b>	<input type="checkbox"/>						
<b>Chinese</b>	<input type="checkbox"/>	<b>Other Ethnic Background</b>	<input type="checkbox"/>						
<b>Information Refused</b>	<input type="checkbox"/>								
<b>Next of kin, their relationship to the patient and their telephone no.</b>									
<input type="text"/>									

Does your child have any known allergies? Yes  No

If yes, please give details.

Does your child suffer with, or is there a family history of, any of the following? Please tick if yes.

	Patient	Family member? - please state relationship to child
Type 1 or 2 Diabetes	<input type="checkbox"/>	<input type="checkbox"/> <input type="text"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/> <input type="text"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/> <input type="text"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/> <input type="text"/>

Does your child currently take any medication and if so what is it for?

Yes  No

If yes, please give details.

Has your child had any surgical procedures? Yes  No

If yes, please give details below.

Date	Surgical Procedure	Hospital
/ /		
/ /		

*Please provide details, if known, of all immunisations given to your child.*

	<i>Date</i>	<i>Place where given</i>	
<i>Diphtheria / Tetanus, Whooping Cough / Polio / HIB</i>	/ /		
	/ /		
	/ /		
<i>Pneumococcal</i>	/ /		
	/ /		
	/ /		
<i>Meningitis C</i>	/ /		
	/ /		
<i>HIB / Meningitis C Booster</i>	/ /		
<i>Measles / Mumps / Rubella</i>	/ /		
<i>Pre-School Diphtheria / Tetanus / Polio Booster</i>	/ /		
<i>Pre-School Measles / Mumps / Rubella Booster</i>	/ /		

**Patient Declaration**

*There is a balance between privacy and good health care. Unless we receive your written instructions to the contrary, we will normally share some information with other health care professionals involved in your care, such as doctors, nurses, therapists and pharmacists.*

*I confirm the information provided on this form is correct and agree to the Practice terms on information sharing*

*Name of Patient*

*Name of Parent / Guardian*

*Signature of Parent / Guardian*

*Date*

 /  / 

***Office Use only:***

***EMIS Number***

***Date of registration and entry onto EMIS*** / /