



New Patient Questionnaire- Child Under 16

<u>Personal Details</u>			
Surname:			
Forename(s):			
Date of Birth:			
Address:			
Post Code:			
Telephone No:			
School:			
Are you housebound? (Please tick) Yes <input type="checkbox"/> No <input type="checkbox"/>		Are you a carer? Yes <input type="checkbox"/> No <input type="checkbox"/> *see below	
Do you have any disabilities or access needs, we need to be aware of?			
Or any communication requirements? E.g. Hearing loop. If so, please state:			
<u>Ethnicity & Language</u>			
The Government has requested that we record the ethnicity and first language of all of our patients. Please circle the category which best describes you:			
White British <input type="checkbox"/>	Mixed British <input type="checkbox"/>	Other Black Background <input type="checkbox"/>	White and Asian <input type="checkbox"/>
White British and Black Caribbean <input type="checkbox"/>	Chinese <input type="checkbox"/>	Other mixed Background <input type="checkbox"/>	Other Asian Background <input type="checkbox"/>
White and Black African <input type="checkbox"/>	Caribbean <input type="checkbox"/>	Pakistani or British Pakistani <input type="checkbox"/>	
Other White Background <input type="checkbox"/>	African <input type="checkbox"/>	Indian or British Indian <input type="checkbox"/>	
Other ethnicity not listed above:			
What is your first language?			
If not English, do you require a translator?			
<u>Family History</u> (Parents, brothers, sisters or children)			
Asthma		Bowel Cancer	
Diabetes		High Cholesterol	
Stroke		Breast Cancer	
Heart Trouble		Other Inherited Disease (please state)	

Lifestyle

How much do you weigh?

What is your height?

Illness, Drugs and Treatment

Please nominate a Pharmacy for prescriptions to go to

**If you are on repeat medication please attach a copy of your repeat prescription slip.
This is available from your pharmacy or previous GP Surgery.**

Please give details of any important illnesses or operations you have had. Please include any dates.

Do you have any allergies?

Yes (please state):

No

Immunisations *Children up to the age of 16* (Based on the Routine childhood immunisation programme 2013) Please indicate which immunisations your child has had and what date they were given.

		Age	Given on (date)
Diphtheria, Tetanus, Pertussis, Polio & Hib	1 st	2 months	
	2 nd	3 months	
	3 rd	4 months	
Diphtheria, Tetanus, Pertussis & Polio	Booster	36 months	
Rotavirus	1 st	2 months	
	2 nd	3 months	
Pneumococcal	1 st	2 months	
	2 nd	4 months	
	3 rd	12 months	
Men C	1 st	3 months	
	2 nd	13-18 Yrs	
Hib/Men C	Booster	12 months	
MMR	1 st	12 months	
	2 nd	36 months	
HPV		12-13 Yrs	
Tetanus, Diphtheria & Polio	Top-up	13-18 Yrs	

- * This is to enable us to support you as a Carer. For example inviting you in for immunisations which you would not normally receive if we did not know you were a Carer

Thank you for taking the time to complete this questionnaire.

Welcome to the Langton Medical Group!