

New Child Patient (Age 7 - 16)



Please complete the following information on behalf of your child and hand your form in to a member of reception staff. **All information is kept strictly confidential.**

Patient Details Male Female

Surname Forename

DOB NHS Number

Parent / Guardian Details

Name Relationship to Child

Email

Address

Postcode

Phone Contact me via email/text

Ethnicity

<input type="checkbox"/> White <input type="checkbox"/> White British <input type="checkbox"/> White Irish <input type="checkbox"/> White Other	<input type="checkbox"/> Black <input type="checkbox"/> Caribbean <input type="checkbox"/> African <input type="checkbox"/> Black Other	<input type="checkbox"/> Other Ethnic Groups <input type="checkbox"/> Chinese <input type="checkbox"/> Any other Ethnic Group <input type="checkbox"/> I do not wish to state my ethnicity
<input type="checkbox"/> Mixed <input type="checkbox"/> White and Black Caribbean <input type="checkbox"/> White and Black African <input type="checkbox"/> White and Asian <input type="checkbox"/> Mixed Other	<input type="checkbox"/> Asian or Asian British <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Asian Other	

First Language (Children and babies ethnicity and first language will be defined as Parent/Guardian)

<input type="checkbox"/> Arabic <input type="checkbox"/> British Signing Language <input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Hindi	<input type="checkbox"/> Urdu <input type="checkbox"/> Bengali <input type="checkbox"/> Tigrinya <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese (Cantonese/Mandarin)	<input type="checkbox"/> Other (please specify below) <input type="text"/>
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Child Protection

Which school does your child attend?

Has your child ever been on the child protection register?

Smoking

Does anyone in your household smoke? Yes No

Smoking in the presence of children is a health risk. If you or anyone in your household would like help and advice to give up smoking, please tick the box.

Urine Analysis (HCA to complete)

Protein

Glucose

Blood

Medication

Is your child on any medication? If so, please specify below.

Name of Medication e.g. Metformin

Dose e.g. 500mg

How many per day e.g. 3 tablets p/day

Allergies

Does your child have any allergies to the following? If so, please tick where appropriate.

Pollen (Hay Fever)

Medicine e.g. Penicillin

Cosmetics

Nuts

Other

Dairy

If you ticked any of the boxes above, please give detail below.

Operations

Has your child had any operations?

Name of Operation

Name of Hospital

Approximate Date

Family History

Is there any family history of the following medical conditions? If so, please tick below.

Asthma Diabetes Hypertension Heart Disease CVA / Stroke Epilepsy Cancer

If you ticked any of the boxes above, please give detail below.

Immunisations Please tick where appropriate

Other, please state

School Boosters (Around 13 Years)

Diphtheria, Tetanus & Polio

MMR

BCG

HPV (cervical cancer)

I

Mother / Father of

confirm that all information given is correct and completed to the best of my ability.

PLEASE SIGN IN THE BOX