**Dr V Patel Surgery**

**9 Glanville Drive, Hornchurch, RM11 3SZ (01708 442117)**

[**www.drvpatelsurgery.nhs.uk**](http://www.drvpatelsurgery.nhs.uk)

**In order to be fully registered with Dr V Patel, this form MUST be completed by the parent/guardian**

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| **NEW PATIENT HEALTH QUESTIONNAIRE (FOR 6 TO 15 YEAR OLDS)** |
| **TITLE:** |  | **FIRST NAME:** |  |
| **SURNAME:** |  |
| **DATE OF BIRTH:** |  | **GENDER:** | **M** **[ ]  F** **[ ]** (please tick) |
| **ADDRESS (incl flat no):** | **ANY OTHER SURGERY PATIENTS LIVING AT THIS ADDRESS?** | **Please give names:** |
|  |
| **IS YOUR CHILD THE LONE OR PARTIAL CARER FOR SOMEONE?****If yes, please specify:** | YES [ ]  NO [ ]  (please tick) |
| **HOME TEL:** |  | **MOBILE TEL:** |  |
| **EMAIL ADDRESS:** |  |
| **WHO DO THESE DETAILS BELONG TO? (e.g. mum, dad, child etc.)** | **MOBILE:** |  |
| **EMAIL:** |  |
| **CAN WE LEAVE MESSAGES REGARDING YOUR CHILD ON THESE NUMBERS?** | **HOME:** | **YES [ ]  NO [ ]** (please tick) |
| **MOBILE:** | **YES [ ]  NO [ ]** (please tick) |
| **NEXT OF KIN:** **(Name, Address, Tel No.)** |  |
| **Pharmacy Details (name and address of preferred pharmacy)** |
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| **Summary Care Record Consent** |
| **Medication, allergies and adverse reactions only** | **YES [ ]  NO [ ]** (please tick) |
| **Medication, allergies, adverse reactions and additional** | **YES [ ]  NO [ ]** (please tick) |
| **Dissent – Patient does not want a summary care record** | **YES [ ]  NO [ ]** (please tick) |

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| **FAMILY HISTORY** |
| **Has a first degree relative of your child (parent or sibling) suffered from any of the following conditions?** (please tick) |
| **Cancer** | **YES [ ]  NO [ ]**  | **Who?** |  | **At what age?** |  |
| **Stroke** | **YES [ ]  NO [ ]**  | **Who?** |  | **At what age?** |  |
| **Heart Disease** | **YES [ ]  NO [ ]**  | **Who?** |  | **At what age?** |  |
| **Diabetes** | **YES [ ]  NO [ ]**  | **Who?** |  | **At what age?** |  |
| **Do any other illnesses run in your family? YES [ ]  NO [ ]** **If Yes, Please give details:** |
| MEDICAL HISTORY |
| **Has your child had/still have any of the following conditions?** (please tick) **:** |
| **High Blood Pressure**(Please add approximate date of diagnosis if known) | **YES [ ]  NO [ ]**  | **Diabetes**(Please add approximate date of diagnosis if known) | **YES [ ]  NO [ ]**  |
| **Heart Disease**(Please add approximate date of diagnosis if known) | **YES [ ]  NO [ ]**  | **Angina**(Please add approximate date of diagnosis if known) | **YES [ ]  NO [ ]**  |
| **Epilepsy**(Please add approximate date of diagnosis if known) | **YES [ ]  NO [ ]**  | **Stroke**(Please add approximate date of diagnosis if known) | **YES [ ]  NO [ ]**  |
| **Asthma** (Please add approximate date of diagnosis if known) | YES [ ]  NO [ ]   | **Cancer**(Please add approximate date of diagnosis if known) | **YES [ ]  NO [ ]**  |
| **If Asthmatic**, have you used your inhaler in past 12 months? | **YES [ ]  NO [ ]**  |
| **Please give details of any other illnesses, accidents, hospital admissions, investigations or operations your child has had :** |
|  | **Date:** |
|  | **Date:** |
|  | **Date:** |
|  | **Date:** |
| **MEDICATION** |
| **IS YOUR CHILD ON ANY REGULAR MEDICATION?**  | **YES [ ]  NO [ ]** (please tick) |
| If Yes, please state name and dose or attach the most recent repeat reorder form(Please note they will be required to see the doctor for a first repeat prescription to be issued) |
| **IS YOUR CHILD ALLERGIC TO ANY MEDICINES?**  | **YES [ ]  NO [ ]** (please tick) |
| **If Yes, please state type and name:** |

**Does your child have a disability?** [ ]  Yes [ ]  No [ ]  Decline to specify

The Disability Discrimination Act 1995 states ‘a person has a disability for the purpose of this ACT if he/she has a physical or mental impairment, which has a substantial and long-term adverse effect on his/her ability to carry out day to day duties.

**Ethnic Origin**

This is not about nationality, place of birth or citizenship. It is about the group to which you perceive your child belongs. Please tick the appropriate box

**White**

English  Welsh  Scottish  Northern Irish  Irish  British  Prefer not to say  Any other white background, please write in:

**Mixed/multiple ethnic groups**

White and Black Caribbean  White and Black African  White and Asian  Prefer not to say  Any other mixed background, please write in:

**Asian/Asian British**

Indian  Pakistani  Bangladeshi  Chinese  Prefer not to say 

Any other Asian background, please write in:

**Black/ African/ Caribbean/ Black British**

African  Caribbean  Prefer not to say 

Any other Black/African/Caribbean background, please write in:

**Other ethnic group**

Prefer not to say  Any other ethnic group, please write in:

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|  Is an interpreter or sign language support needed? | **Yes** | [ ]  | **No** | [ ]  |

**Patient Services**

We offer an online service for our patients so you can book your appointments, order your repeat prescriptions and have online access to your medication history and allergies online at your convenience.

**Online appointment booking**

Have the flexibility to book and cancel your appointments from home, at work or any location with internet access. You don’t need to queue at the practice, wait on the telephone and you can manage your appointments outside practice opening hours.

**Request your repeat prescriptions online**

Request your repeat prescriptions quickly online by logging into your account and simply ticking the appropriate boxes. You can review the progress of your repeat prescriptions and any message that the practice may have sent to you.

**Access to your GP record online**

Take greater control of your health and wellbeing by being able to view your medication history, allergies and adverse reactions online.

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**Patient Services - Patient registration form**

To register please complete the form below and return it to the practice in person, **along with a valid form of identification (e.g. photo ID or your passport).** Once registered we will give you the information that will enable you to create a username and password.

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| --- | --- |
| **Patient details** |  **Please complete in BLOCK CAPITALS** |
| Patient forename |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Patient surname |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Date of birth | D | D | / | M | M | / | Y | Y | Y | Y |  |
| Email address**This email address will be used by your practice to send you notifications and reminders.**  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |
| Mobile number |  |  |  |  |  |  |  |  |  |  |  |  |
| Signature |  |
| Date | D | D | / | M | M | / | Y | Y | Y | Y |  |  |  |  |  |  |  |  |  |  |
| **Completing the form on behalf of the patient?** |
| Print forename |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Print surname |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Relationship to patient |  |
| Signature |  |
| Date | D | D | / | M | M | / | Y | Y | Y | Y |  |

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| **Staff use only** |  |
| Patient ID seen  |  |
| Type of ID |  |
| Staff name |  |
| Date  | D | D | / | M | M | / | Y | Y | Y | Y |  |