KINGS ROAD SURGERY

2 – 6 Kings Road, Mumbles, Swansea, SA3 4AJ

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

Dr Tom Watkins, MBBS, MRCGP Tel: (01792) 360933

Dr Lynne Dowding, MBBCh, MRCGP, DCH, Dip Pall Med.

Dr Jane Chivers, MBBCh, MRCGP, DRCOG

**New Patient Health Questionnaire – Child Under 16 Years of Age**

The questions below have been designed to help your new General Practitioner get to know your child and his/her medical problems.

The information you provide will be handled confidentially by your doctor but if you are concerned about any of the questions, please leave them blank.

**Please give details of child under 16:**

|  |  |
| --- | --- |
| **Title:** | **Date Of Birth:** |
| **Full Name:** |
| **Address:** |
| **Postcode:** | **Telephone No:** |
| **Nationality:** |

**Please give details of child’s mother:**

|  |
| --- |
| **Full Name and Title:** |
| **Date of Birth:** |
| **Address & Postcode** | **Home Tel No:****Work Tel No:****Mobile No:** |
| **Email Address:**  |

**Please give details of child’s father:**

|  |
| --- |
| **Full Name and Title:** |
| **Date of Birth:** |
| **Address & Postcode:** | **Home Tel No:****Work Tel No:****Mobile No:** |
| **Email Address:** |

**Carers**

Is your child a carer? i.e. looking after a friend or relative? ……………………………………… Y**es/No**

In order that his/her GP can do all that he/she can do to help, it is important that he/she is aware of your child’s status as a carer.

If you answered “YES”, please ask the receptionist for “Carer Forms”

**Name and address of school attended:**

|  |
| --- |
|  |

**Does your child have any allergies? Yes / No (Please delete as appropriate)**

|  |
| --- |
| **If yes, please give details:** |

**Past Health - Illnesses, Accidents or Operations**

|  |
| --- |
| Please list all SERIOUS ILLNESSES, ACCIDENTS, HOSPITAL ADMISSIONS OR OPERATIONS with dates and details of hospital below: |

**Present Health**

|  |
| --- |
| Please state any ongoing condition(s) including any disability that your child suffers from: |

**Current Medication**

|  |
| --- |
| Please list present medications below or state “None”: |

**Is there any other information that you think your Doctor might need to know (please include detail of any sensory impairment e.g. speech, hearing or visual)?**

|  |
| --- |
| Please give details of any other information |

**As far as you are aware, are you up to date with your routine childhood immunisations?**

|  |
| --- |
| **Yes / No (please delete as appropriate)**If No please list vaccines that you have **NOT** had; |

**Please See Continuation Sheet**

**Patient Ethnic Origin Questionnaire**

*This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the Race Relations Act.*

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

**Name…………………………………………. Date of Birth………………………………….**

A White

|  |  |
| --- | --- |
|   | British |
|  | Irish |
|  | Any other white background please write in below |

|  |
| --- |
|  |

B Mixed

|  |  |
| --- | --- |
|  | White and Black Caribbean |
|  | White and Black African |
|  | White and Asian |
|  | Any other mixed background please write below |

|  |
| --- |
|  |

C Asian or Asian British

|  |  |
| --- | --- |
|  | Indian |
|  | Pakistani |
|  | Bangladeshi |
|  | Any other Asian background please write below |

|  |
| --- |
|  |

D Black or Black British

|  |  |
| --- | --- |
|  | Caribbean |
|  | African |
|  | White and Asian |
|  | Any other black background please write below |

|  |
| --- |
|  |

E Chinese or other ethnic group

|  |  |
| --- | --- |
|  | Chinese |
|  | Any other please write below |

|  |
| --- |
|  |