ILKLEY & WHARFEDALE
MEDICAL PRACTICE

CHILD NEW PATIENT QUESTIONNAIRE
(Under 16)

There can be a delay in receiving your medical records from your previous practice. In the meantime this questionnaire will provide the doctors with important information about your child's history and will help us to give you a better service. Please complete as fully as possible.

PATIENT DETAILS

Title:	**Master □** **Miss □**	**Surname:**	
Date of Birth:		**First Name:**	
Previous Surnames:			
Home Address: **Postcode:** **NHS Number:**		**Home Tel:**	
		Mobile:	
		Email:	
		OFFICE USE ONLY: **Patient registered for on-line access:-** **Proxy (0-11)** **Gillick competent (11-16)**	 **□** **□**
Parent/Guardian:		**Relationship:**	
Parent/Guardian Address and Telephone Number:			

ETHNIC GROUP

White	**British □**	**Irish □**	**Other □ (please specify)**
Black	**Caribbean □**	**African □**	**Other □ (please specify)**
Asian	**Indian □**	**Pakistani □**	**Chinese □** **Other □ (please specify)**
Mixed	**White and Black Caribbean □**		**White and Black African □**
	White and Asian □		**Other □ (please specify)**

What is your child's first language?	**Does your child speak English?**

PROOF OF ID AND ADDRESS WILL BE REQUIRED AND A COPY TAKEN OF ID DETAILS

□ Birth Certificate	**□ Passport**

MEDICAL INFORMATION

Please list any serious illnesses/operations/accidents/disabilities			
Have your child suffered from? (tick as appropriate)			
Epilepsy	**□ Yes □ No**	**Blindness**	**□ Yes □ No**
Cancer	**□ Yes □ No**	**Diabetes**	**□ Yes □ No**
Eczema/Hay Fever	**□ Yes □ No**	**Depression**	**□ Yes □ No**
		Asthma	**□ Yes □ No**
Please list any medications being taken and the amount			
Medication:		**Dosage:**	
Is your child allergic to any medicines and if so which?			**□ Yes □ No**
If yes please provide details:			
Has your child any non-medication allergies?			**□ Yes □ No**
If yes please provide details:			

DISABILITIES AND OTHER NEEDS (Accessible Information Standard)

It is important for us to identify and log a patient's requirements in their medical notes if they have a recorded disability.

Registered Blind	**□ Yes □ No**	**Visual Impairment**	**□ Yes □ No**
Registered Partially Sighted	**□ Yes □ No**	**Hearing Difficulties**	**□ Yes □ No**
Registered Deaf	**□ Yes □ No**	**Use of Hearing Aids**	**□ Yes □ No**
Registered Deaf/Blind	**□ Yes □ No**	**Other:**	
Learning Disability	**□ Yes □ No**		
Does your child have any communication/information needs relating to a disability or sensory loss and if so what they are? For example, letters printed in size 28 plus font.			

OTHER INFORMATION

Height and Weight			
What is your child's height?		**What is your child's weight?**	

ELECTRONIC PRESCRIPTIONS (none paper)

Electronic prescribing is a computer-based electronic generation and transmission of a prescription to a pharmacy of your choice taking the place of a paper or faxed prescription. This is done to streamline the process of ordering prescriptions for both patient and the practice.

Would you like to use Electronic Prescribing?	**□ Yes □ No**
If yes please tick the pharmacy of your choice:	
Boots, Brook Street, Ilkley	□
Cohens Chemist, Burley in Wharfedale	□
Ilkley Moor Pharmacy, Cowpasture Road, Ilkley	□
Lloyds Pharmacy, Springs Lane, Ilkley	□
Rowlands, Main Street, Addingham	□

Thank you for taking the time to complete this medical questionnaire, the information you have supplied will help improve our service to you. All new patients are asked to make an appointment with our Practice Nurse for a Health Check. This will include a basic health questionnaire along with height, weight and blood pressure measurement. It would be appreciated if you could provide a urine sample (sample bottles are available at our reception desk).

<u>THE INFORMATION GIVEN IS IN STRICTEST CONFIDENCE AND ONLY USED BY YOUR HEALTH PROFESSIONAL</u>

Signature of parent/guardian	**Date**