

For Official Use Only:

Form Accepted by:	
New patient health check appointment	

Dear Parent/Guardian

By answering the questions on this form you will be helping us to deliver better services to your child. It is hoped that this will give us a better picture of the local population, which will help in planning new services and changing existing ones.

We encourage all patients to complete this form on behalf of your child. The information you provide will be treated in the strictest confidence. Information you give will be treated in the same way as other information we hold within the health service and will not breach the Data Protection Act 2003. As has always been the case, no names or other identifying details are released from the practice when information is used for health service planning.

If you need any help to fill in this form, any **communication support needs** (i.e. large print, easy read format, hearing aid, British Sign Language, language interpreter) or have any queries regarding this form, please feel free to ask the reception team.

Thank you for your help.

Master  Miss  Other

Surname \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

First Name(s) \_\_\_\_\_

Previous Surname \_\_\_\_\_

NHS Number \_\_\_\_\_

Male  Female

Home Address

\_\_\_\_\_

Telephone Number: 020 \_\_\_\_\_

Mobile Number \_\_\_\_\_

E-mail Address *(this will only be used for surgery correspondence)*

\_\_\_\_\_

**Please help us to trace your previous medical records by providing the following information;**

Previous Address in the UK

\_\_\_\_\_

\_\_\_\_\_

Name and Address of your previous doctor

\_\_\_\_\_

\_\_\_\_\_

**If you are from abroad**

Your first UK address where registered with a GP

\_\_\_\_\_

\_\_\_\_\_

Date you entered the UK \_\_\_\_\_

Country of Birth:

Place of Birth:

**Are you a carer?**

i.e. Do you look after a friend or a relative who is sick, disabled, elderly has a mental health problem or for any other reason?

Yes  No **Are you cared for?**

i.e. Do you have a friend or relative who helps you live your day to day life?

Yes  No 

If yes please give details of your carer's contact information:

Name \_\_\_\_\_

Contact Number: \_\_\_\_\_

**Family Details \*\*\* (COMPULSORY TO FILL IN) \*\*\***

<b>Mother's Name</b>		<b>Contact no:</b>	<b>Registered at Allerton Road Medical Centre?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Father's Name</b>		<b>Contact no:</b>	<b>Registered at Allerton Road Medical Centre?</b> Yes <input type="checkbox"/> No <input type="checkbox"/>

**Brothers, Sisters or other children's details living in your home \*\*\* (COMPULSORY TO FILL IN) \*\*\***

<b>Surname</b>	<b>First Name</b>	<b>Date Of Birth</b>

**Name, Address & Telephone Numbers****Child Minder \*\*\* (COMPULSORY TO FILL IN) \*\*\***

<b>Name:</b>	<b>Contact no:</b>
<b>Address:</b>	

**Nursery \*\*\* (COMPULSORY TO FILL IN) \*\*\***

<b>Name:</b>	<b>Contact no:</b>
<b>Address:</b>	

**School \*\*\* (COMPULSORY TO FILL IN) \*\*\***

<b>Name:</b>	<b>Contact no:</b>
<b>Address:</b>	

## Child Examinations

6 Week Examination	Date:
7-9 Month Examination	Date:
2 Year Examination	Date:
3 ½ Year Examination	Date:

## Immunisations

BCG (Usually given before child's 1 <sup>st</sup> birthday)	Date:
Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type b, Pneumococcal, Rotavirus (2 months old)	Date:
Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type b, Meningococcal C Rotavirus (3 months old)	Date:
Diphtheria, Tetanus, Pertussis, Polio, Haemophilus influenza type b, Pneumococcal (4 months old)	Date:
Hib/Men C Pneumococcal Measles, Mumps, Rubella (12 months old)	Date:
Measles, Mumps, Rubella ( 15 months old)	Date:
Diphtheria, Tetanus, Pertussis, Polio, (3years 4 months or soon after)	Date:
Human Papillomavirus (girls only aged 12 – 13yrs)	1 <sup>st</sup> Jab Date: 2 <sup>nd</sup> Jab Date: 3 <sup>rd</sup> Jab Date:
Diphtheria, Tetanus, Polio, Meningococcal C (13-18 years old)	Date:

If there are any other vaccines your child has had that are not listed above please use the space below to provide the details of the jab, name and date they were given.

Has your child had any serious illnesses or operations in the past, if so please give details in this space.

**Does your child have any current medical conditions?**

Name of condition	Current treatment / Medication?

**Does your child have any allergies?**

Medication	Food	Anything Else

**\*\*\* EPS (Electronic Prescription Service) \*\*\*\***

**EPS makes it easy for your prescriptions to be sent electronically to the pharmacy or dispenser of your choice.**

**\*\*\* Nominated pharmacy : \_\_\_\_\_ Postcode: \_\_\_\_\_**

**Smoking**

If your child is over the age of 15 please can you tell us if they smoke?

Smoker: Yes  No

If yes how many?

**Ethnic Status & Nationality**

What is your child's country of birth? \_\_\_\_\_ What is your child's main spoken language? \_\_\_\_\_

What language does your child prefer to read? \_\_\_\_\_

**Please tell us your child's ethnic group by ticking the box**

- |                         |                          |                        |                          |
|-------------------------|--------------------------|------------------------|--------------------------|
| White British           | <input type="checkbox"/> | Black or Black British | <input type="checkbox"/> |
| White Irish             | <input type="checkbox"/> | African                | <input type="checkbox"/> |
| White Scottish          | <input type="checkbox"/> | Caribbean              | <input type="checkbox"/> |
| White Welsh             | <input type="checkbox"/> |                        |                          |
| Asian or Asian British  | <input type="checkbox"/> | Chinese                | <input type="checkbox"/> |
| Bangladeshi             | <input type="checkbox"/> | Vietnamese             | <input type="checkbox"/> |
| Indian                  | <input type="checkbox"/> |                        |                          |
| Pakistani               | <input type="checkbox"/> |                        |                          |
| Mixed Background        | <input type="checkbox"/> |                        |                          |
| White & Asian           | <input type="checkbox"/> |                        |                          |
| White & Black African   | <input type="checkbox"/> |                        |                          |
| White & Black Caribbean | <input type="checkbox"/> |                        |                          |

Any other ethnic background please write. \_\_\_\_\_

SIGNATURE ON BEHALF OF CHILD: \_\_\_\_\_ DATE \_\_\_\_\_

Are you, please circle one of the following: Child's parent Foster Parent Guardian

**Thank you for taking time to complete this.  
Please ask at reception for a practice leaflet to explain the services we offer**