Alyn Meddygon Teulu Alyn Family Doctors

New Patient Questionnaire for **Patients Under 16 Years of Age**

Please complete the following information and attached forms. It is important that we have ALL of the child's current details to process their registration. Please be assured that all information is confidential.

Personal Details:

Patients full name: ……

Previous name (if applicable):……

NHS Number:……

DOB: ……

Gender:……..

Current address: ……

……

Previous address: ……

……

Home Tel No: ……..

Mobile No and relation of phone owner to patient: ……

Do you consent to the practice contacting you by text message regarding the patient under 16 years of age, for appointment reminders, invitations to health checks, vaccination reminders, to let you know that your prescription or your sick note is ready for collection and anything else relevant to your healthcare? *Yes/No (please delete as appropriate)

Email address: ……

Do you consent to the practice contacting you by email regarding the patient under 16 years of age?

*Yes/No (please delete as appropriate)

Name & address of current GP: ……..

……

Next of kin Name : ……Relation:……

Emergency contact telephone number: ……

Height:…… Weight:……

BMI:……

Please note the following information you supply may assist us to provide good care for a child whilst we await their previous medical records.

Medical history:

Please list all serious illnesses, medical conditions, past operations or any disabilities:

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……

Have they suffered from: (Brief details)

Heart attack: YES/NO ……

Stroke YES/NO ……

High blood pressure YES/NO ……

Diabetes YES/NO ……

Asthma YES/NO ……

COPD YES/NO ……

Epilepsy YES/NO ……

Hypothyroidism YES/NO ……

Mental health illness YES/NO ……

Depression YES/NO ……

Family history:

Is there any family history of the following (if YES please give details ie relationship)

Heart disease: YES/NO ……

Asthma: YES/NO ……

Diabetes: YES/NO ……

Stroke: YES/NO ……

Cancer: YES/NO ……

Stomach problems: YES/NO ……

Allergies

Dose the child have any allergies? Yes/No

If Yes, please give details:……

……

Medication:

Dose the child take any regular medication: YES/NO

If YES we require a copy of a recent prescription. If you are unable to provide this, we will require a print out from your GP. Medication will not be prescribed without this.

Please give details of any medication which you take (prescribed or otherwise):

Name of Drug	Dosage

Electronic prescribing service (EPS)

Has the child ever been registered in England? Yes / No

Do they have an historic EPS pharmacy nomination? Yes/ No

If we discover an historic nomination, do we have permission to remove it? Yes/ No

Choose your nominated pharmacy for EPS : Llay, Gresford or Rossett

Is the child a carer? YES/NO

If YES who do they care for:…….

Dose your child have a social worker? Yes / No

If yes please provide further details……

……

Dose the child or guardian have a disability, impairment or sensory loss which requires additional support with information and communication? If yes please advise apreferred method of contact (such as telephone, text email etc) and if you require an interpreter at face-to-face appointments.

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Signature …….

(Patient/Parent/Guardian)

Date form completed ……

Thank you for completing the questionnaire.