CHILDREN'S QUESTIONNAIRE

Please complete as many questions as you can about your child. The information will help the practice to provide better medical care for your family.

Today's Date: …………………..

Child's Surname: ………………. Parent's Surname: ……………. Tel: No.: …………..

Child's First Name: ……………………………………………… Date of Birth: …………..

Next of Kin: ……………………………………………………

Place of Birth: ……………………………………………………. Birth Weight: …………..

Address: ……………………………………………………………………………………...

……………………………………………………………………………………………

Previous Address: ………………………………………………………………………………

Name and Address of Previous Doctor: …………………………………………………………

……………………………………………………………………………………………………

School: ……………………………………………………………………………………….

MEDICATION

Is your child on any regular medication? YES/NO

If YES, please give details: ………………………………………………………………………

ALLERGIES

Is your child allergic to any drugs? YES/NO

If YES, please give details: ………………………………………………………………………..

Does your child suffer from any other allergies? YES/NO

If YES, please give details: ………………………………………………………………………

SPECIAL NEEDS

Does your child have any hearing or eyesight problems? YES/NO

If YES, please give details: ………………………………………………………………………..

Does your child have any special educational needs? YES/NO

If YES, please give details: ………………………………………………………………………..

HOSPITAL WAITING LISTS

Is your child on a hospital waiting list, awaiting treatment? YES/NO

If YES, please give details as follows: Hospital: ……………………………………

Consultant: ……………………….…….. Treatment: …………………………………………………

Date on Waiting List: …………………………(Please give an approximate date if you do not have an exact one.)

CHILD'S MEDICAL HISTORY

Were there any important complications in the birth of your child? YES/NO

If YES, please give details: ……………………………………………………………………..

Has your child had any of the following: (Please tick and give an approximate date.)

	Tick	Date		Tick	Date
Asthma			Measles		
Chicken Pox			Mumps		
Fits			Whooping Cough		
German Measles					

Has your child had any serious illness or accidents? YES/NO

If YES, please give details: ……………………………………………………………………..

Has your child ever been admitted to hospital? YES/NO

If YES, please give details: ……………………………………………………………………..

IS THERE ANY HISTORY OF FITS/EPILEPSY IN CHILD'S PARENTS/BROTHERS/SISTERS YES/NO

IMMUNISATION/VACCINATIONS (please enter details below, indicating whether the immunization by your GP/Health Clinic or privately.)

IMMUNISATION/VACCINATION	GIVEN BY GP/HEALTH CLINIC	GIVEN PRIVATELY	DATE
BCG			
1st Diphtheria/Pertussis/Tetanus/Polio/Hib/PCV			
2nd Diphtheria/Pertussis/Tetanus/Polio/Hib/Men C			
3rd Diphtheria/Pertussis/Tetanus/Polio/Hib/Men C/PCV			
Men C/Hib (Menitorix)			
Measles/Mumps/Rubella (MMR)			
3rd PCV			
Pre-School Booster (Diphtheria/Tetanus + Polio) 2nd MMR			

Office Use Only

Height: ………………. Weight: …………………. BP: ……………. Urine: ………………...

MOT Appointment: ……………………………………………………………………………………

NHS

Family doctor services registration

GMS1

Patient's details

Please complete in BLOCK CAPITALS and tick ☑ as appropriate

☐ Mr ☐ Mrs ☐ Miss ☐ Ms

Surname

Date of birth

First names

NHS No.

Previous surname/s

☐ Male ☐ Female

Town and country of birth

Home address

Postcode

Telephone number

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

Your previous address in UK

Name of previous doctor while at that address

Address of previous doctor

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving

Date you first came to live in UK

If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number

Enlistment date

If you are registering a child under 5

☐ I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

☐ I live more than 1 mile in a straight line from the nearest chemist

☐ I would have serious difficulty in getting them from a chemist

*Not all doctors are authorised to dispense medicines

☐ Signature of Patient ☐ Signature on behalf of patient

Date ____/____/____

Version 01/02

Please see overleaf re: Organ donation

NHS

Family doctor services registration

GMS1

NHS Organ Donor registration

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

☐ Any of my organs and tissue or

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature confirming my agreement to organ/tissue donation **Date** ____/____/____

For more information, please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk, or call 0845 60 60 400.

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years ☐

Signature confirming consent to inclusion on the NHS Blood Donor Register **Date** ____/____/____

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

To be completed by the doctor

Doctors Name

HA Code

☐ I have accepted this patient for general medical services

☐ For the provision of contraceptive services

☐ I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, *if different from above*

HA Code

☐ I am on the HA CHS list and will provide Child Health Surveillance to this patient or

☐ I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, *if different from above*

HA Code

☐ I will dispense medicines/appliances to this patient subject to Health Authority's Approval

☐ I am claiming rural practice payment for this patient.
Distance in miles between my patient's home address and my main surgery is

I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name

Date ____/____/____

Practice Stamp

HA use only Patient registered for ☐ GMS ☐ CHS ☐ Dispensing ☐ Rural Practice