**Patient Questionnaire – Under 16**

**We use this information to understand more about you and make sure we know about any care you are getting, including any medications you take. It is really important that you complete all the form and that we can understand the information so we record it correctly – please complete using BLOCK CAPITALS, sign and scan to us (or bring in) with your registration form, thank you**.

Name             Date of Birth

Address

Telephone Number       E- Mail

### We use text messaging to send notification about appointment reminders, flu clinics, health promotion information, cancellation of clinics, changes in service provision and results. You can opt out of this service at any time by phoning 01224 492828.

**I agree to being contacted by text** …………………………………………………………………………… Signature

What ethnic group do you belong to? (you do not have to tell us but it is helpful if you do)

[ ]  White [ ]  Chinese [ ]  Indian [ ]  Bangladeshi [ ]  Pakastani [ ]  Black-African [ ]  Black Carribbean

[ ]  Other, please state

What is your main spoken language?       Do you need an interpreter? [ ]  Yes [ ]  No

Are you an unpaid carer (looking after a family member, friend or neighbour who needs help) [ ]  Yes [ ]  No

If yes, would you like us to refer you for advice on the help available for carers [ ]  Yes [ ]  No

**Medical Information**

**Previous Serious Illnesses –** [ ]  Yes [ ]  No If yes – please list -

Condition       Date

Condition       Date

Condition       Date

Condition       Date

**Any operations?** [ ]  Yes [ ]  No If yes – please list –

Operation       Date

Operation       Date

Operation       Date

Please provide a list of any medications you are taking at the moment – we will need to see confirmation of these being prescribed by your previous GP (summary from previous GP or pictures of prescribed medication)

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Strength** | **How often taken** | **Reason for taking** |
|        |        |        |        |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |
|       |       |       |       |

**Do you have any drug allergies** [ ]  Yes [ ]  No If yes, please list –

Are you a smoker (over 14) [ ]  Yes – number per day       [ ]  Ex-smoker – date stopped       [ ]  Never smoked

How tall are you?       How much do you weigh?

**Immunisations (must be completed)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Immunisation** | Age Normally Given | Date of Immunisation |  |
| **Diphtheria/Tetanus/Pertussis (Whooping cough)****Polio (IPV)** | 2 months | 1st dose |  |       |  |  |
| 3 months | 2nd dose |  |       |  |
| 4 months | 3rd dose |  |       |  |
| 3yr4m – 5 year | 4th dose |  |       |  |  |
| **HIB (Haemophilus)** | 2 months | 1st dose |  |       |  |  |
| 3 months | 2nd dose |  |       |  |  |
| 4 months | 3rd dose |  |       |  |  |
| 12 months | 4th dose |  |       |  |  |
| **PCV (Pneumococcus)** | 2 months | 1st dose |  |       |  |  |
| 4 months | 2nd dose |  |       |  |  |
| *13 months* | *3rd dose* |  |       |  |  |
| **Meningitis C** | *3 months* | *1st dose* |  |       |  |  |
| *4 months* | *2nd dose* |  |       |  |
| *12 months* | *3rd dose* |  |       |  |
| **MMR (Measles/Mumps/Rubella)** | *13-18 months* | *1st dose* |  |       |  |  |
|  | *3yr4m - 5 years* | *2nd dose* |  |       |  |  |
| **Diphtheria/Tetanus** | *13-18 years* | *1st dose* |  |       |  |  |
| **Polio (IPV)** | *13-18 years* | *5th dose* |  |       |  |  |
| ***Other immunisations (please list below)*** |  |
| *Immunisation* | *Date* | *Immunisation* | *Date* |  |
|       |       |       |       |  |
|       |       |       |       |  |
|       |       |       |       |  |

Date Form Completed ……………………….. Signature ………………………………………………………………………………………………..