

BRUNTSFIELD MEDICAL PRACTICE

11 Forbes Road, Edinburgh, EH10 4EY

Date Form Completed:	
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In order to be fully registered with this practice, this form
MUST be completed by the parent/guardian

NEW PATIENT HEALTH QUESTIONNAIRE (FOR 6 TO 15 YEAR OLDS)

TITLE:		FIRST NAME:	
SURNAME:			
DATE OF BIRTH:		GENDER:	M <input type="checkbox"/> F <input type="checkbox"/> (please tick)
ADDRESS (incl flat no):	WHO ELSE LIVES IN THIS HOUSEHOLD?		
	IS YOUR CHILD THE LONE OR PARTIAL CARER FOR SOMEONE? If yes, please specify:		YES <input type="checkbox"/> NO <input type="checkbox"/> (please tick)
HOME TEL:		MOBILE TEL:	
EMAIL ADDRESS:			
WHO DO THESE DETAILS BELONG TO? (e.g. mum, dad, child etc.)	MOBILE:		
	EMAIL:		
CAN WE LEAVE MESSAGES REGARDING YOUR CHILD ON THESE NUMBERS?	HOME:	YES <input type="checkbox"/> NO <input type="checkbox"/> (please tick)	
	MOBILE:	YES <input type="checkbox"/> NO <input type="checkbox"/> (please tick)	
NEXT OF KIN: (Name, Address, Tel No.)			

HOW DID YOU FIND OUT ABOUT THE PRACTICE / DECIDE TO REGISTER WITH US?			
I've been registered here before	<input type="checkbox"/>	I have family registered here	<input type="checkbox"/>
NHS helpline or website	<input type="checkbox"/>	Non-NHS ad or weblink	<input type="checkbox"/>
		General word of mouth	<input type="checkbox"/>
		Search engine (e.g. Google)	<input type="checkbox"/>
Other (please specify):			

MEDICATION

IS YOUR CHILD ON ANY REGULAR MEDICATION?	YES <input type="checkbox"/> NO <input type="checkbox"/> (please tick)
If Yes, please state name and dose:	
(Please note they will be required to see the doctor for a first repeat prescription to be issued)	
IS YOUR CHILD ALLERGIC TO ANY MEDICATION?	YES <input type="checkbox"/> NO <input type="checkbox"/> (please tick)
If Yes, please state type and name:	

MEDICAL HISTORY

HAS YOUR CHILD HAD/STILL HAVE ANY OF THE FOLLOWING (please tick) :			
High Blood Pressure <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>	Diabetes <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Heart Disease <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>	Angina <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Epilepsy <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>	Stroke <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>
Asthma <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>	Cancer <small>(Please add approximate date of diagnosis if known)</small>	YES <input type="checkbox"/> NO <input type="checkbox"/>
If Asthmatic , have they used their inhaler in past 12 months?	YES <input type="checkbox"/> NO <input type="checkbox"/>		
Please give details of any other illnesses, accidents, hospital admissions, investigations or operations your child has had :			
			Date:
			Date:
			Date:
			Date:

FAMILY HISTORY

Has a first degree relative of your child (parent or sibling) suffered from any of the following conditions? (please tick)					
Cancer	YES <input type="checkbox"/> NO <input type="checkbox"/>	Who?		At what age?	
Stroke	YES <input type="checkbox"/> NO <input type="checkbox"/>	Who?		At what age?	
Heart Disease	YES <input type="checkbox"/> NO <input type="checkbox"/>	Who?		At what age?	
Diabetes	YES <input type="checkbox"/> NO <input type="checkbox"/>	Who?		At what age?	
Do any other illnesses run in your family? YES <input type="checkbox"/> NO <input type="checkbox"/>					
If Yes, Please give details:					

ETHNICITY & LANGUAGE QUESTIONNAIRE

This short questionnaire will give surgery staff some basic information about your communication support needs and ethnicity, to support your health care.

We would be grateful if you could complete **one form for each family member** within/joining the practice

NAME _____ **DOB** _____

What is your main language?

Do you need an interpreter or sign language support? **Yes** **No**

WHAT IS YOUR ETHNIC GROUP?

Choose **ONE** section from A to F then tick **ONE** box which **best describes** your ethnic group or background

A. White	
Scottish	<input type="checkbox"/>
English	<input type="checkbox"/>
Welsh	<input type="checkbox"/>
Northern Irish	<input type="checkbox"/>
British	<input type="checkbox"/>
Irish	<input type="checkbox"/>
Gypsy/Traveller	<input type="checkbox"/>
Polish	<input type="checkbox"/>
Any other white ethnic group, please specify below:	
<input style="width: 100%; height: 20px;" type="text"/>	

C. Asian, Asian Scottish, or Asian British	
Pakistani, Pakistani Scottish, or Pakistani British	<input type="checkbox"/>
Indian, Indian Scottish or Indian British	<input type="checkbox"/>
Bangladeshi, Bangladeshi Scottish, or Bangladeshi British	<input type="checkbox"/>
Chinese, Chinese Scottish, or Chinese British	<input type="checkbox"/>
Other Asian, please specify:	
<input style="width: 100%; height: 20px;" type="text"/>	

B. Mixed or multiple ethnic groups	
Any mixed or multiple ethnic group	<input type="checkbox"/>

D. African	
African, African Scottish, or African British	<input type="checkbox"/>
Other African, please specify:	
<input style="width: 100%; height: 20px;" type="text"/>	

E. Caribbean or Black	
Caribbean, Caribbean Scottish, or Caribbean British	<input type="checkbox"/>
Black, Black Scottish, Black British	<input type="checkbox"/>
Other Caribbean or Black, please specify:	
<input style="width: 100%; height: 20px;" type="text"/>	

F. Other ethnic group	
Arab	<input type="checkbox"/>
Other, please specify:	
<input style="width: 100%; height: 20px;" type="text"/>	

If you would prefer not to provide this information, please tick here:	<input type="checkbox"/>
If you don't know your ethnicity, please tick here:	<input type="checkbox"/>