# BRUNTSFIELD MEDICAL PRACTICE

**11 Forbes Road, Edinburgh, EH10 4EY**

**In order to be fully registered with this practice, this form MUST be completed and signed by the parent/guardian**

| NEW PATIENT HEALTH QUESTIONNAIRE (FOR CHILDREN UNDER 6Y) | | | | | |
|---|---|---|---|---|---|
| **TITLE:** | | **FIRST NAME:** | | | |
| **SURNAME:** | | | | | |
| **DATE OF BIRTH:** | | **GENDER:** | **M** ☐ **F** ☐ (please tick) | | |
| **ADDRESS (incl flat no):** | | **WHO ELSE LIVES IN THIS HOUSEHOLD?** | (please include age and relationship to child) | | |
| **HOME TEL:** | | **MOBILE TEL:** | | | |
| **EMAIL ADDRESS:** | | | | | |
| **WHO DO THESE DETAILS BELONG TO? (e.g. mum, dad etc.)** | **MOBILE:** | | | | |
| | **EMAIL:** | | | | |
| **CAN WE LEAVE MESSAGES REGARDING YOUR CHILD ON THESE CONTACTS?** | **HOME:** | **YES** ☐ **NO** ☐ (please tick) | | | |
| | **MOBILE:** | **YES** ☐ **NO** ☐ (please tick) | | | |
| | **EMAIL:** | **YES** ☐ **NO** ☐ (please tick) | | | |
| **NEXT OF KIN: (Name, Address, Tel No.)** | | | | | |

| MEDICATION | |
|---|---|
| **IS YOUR CHILD ON ANY REGULAR MEDICATION?** | **YES** ☐ **NO** ☐ (please tick) |
| **If Yes, please state name and dose:** | |
| ********(Please note that you need to see a GP, if on existing medication, for a first repeat prescription to be issued. Make an appointment with a GP for a review of your medication in good time and before you run out!)******** | |
| **IS YOUR CHILD ALLERGIC TO ANY MEDICATION?** | **YES** ☐ **NO** ☐ (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** (Please add approximate date of diagnosis if known) | **YES** ☐ **NO** ☐ **Date:** | **Diabetes** (Please add approximate date of diagnosis if known) | **YES** ☐ **NO** ☐ **Date:** |
| **Heart Disease** (Please add approximate date of diagnosis if known) | **YES** ☐ **NO** ☐ **Date:** | **Angina** (Please add approximate date of diagnosis if known) | **YES** ☐ **NO** ☐ **Date:** |
| **Epilepsy** (Please add approximate date of diagnosis if known) | **YES** ☐ **NO** ☐ **Date:** | **Stroke** (Please add approximate date of diagnosis if known) | **YES** ☐ **NO** ☐ **Date:** |
| **Asthma** (Please add approximate date of diagnosis if known) | **YES** ☐ **NO** ☐ **Date:** | **Cancer** (Please add approximate date of diagnosis if known) | **YES** ☐ **NO** ☐ **Date:** |
| **If Asthmatic**, have you used your inhaler in past 12 months? | **YES** ☐ **NO** ☐ **Date:** | | |

**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** ☐ **NO** ☐ | **Who?** | | **At what age?** | |
| **Stroke** | **YES** ☐ **NO** ☐ | **Who?** | | **At what age?** | |
| **Heart Disease** | **YES** ☐ **NO** ☐ | **Who?** | | **At what age?** | |
| **Diabetes** | **YES** ☐ **NO** ☐ | **Who?** | | **At what age?** | |

**Do any other illnesses run in your family? YES** ☐ **NO** ☐

**If Yes, Please give details:**

## CONTACT WITH OTHER AGENCIES

Under the current Child Health & Wellbeing Guidance, we are obliged to ask the following for all new registrations to the Practice between the ages of 0-16 years.

**Does anyone in your household currently have contact with any of the following support services?**

| | | |
|---|---|---|
| **A.** Social Work Department | ☐ YES | ☐ NO |
| **B.** Mental Health Services | ☐ YES | ☐ NO |
| **C.** Drug/Alcohol Support Services | ☐ YES | ☐ NO |

If yes to any, can you give brief details:

Please note **without immunisation history we are unable to fully register children**. A current photocopy of the immunisation history is the preferred option (e.g. from the red book); we can take a photocopy of this at reception. If this is not available then please list below.
If you are from a country with a different immunisation schedule, please edit the details below as appropriate.

| **IMMUNISATIONS** | **DATE GIVEN** |
|---|---|
| 1st Diphtheria, Tetanus, Pertussis (Whooping Cough) / Polio / Hib / Hep B | |
| 2nd Diphtheria, Tetanus, Pertussis (Whooping Cough) / Polio / Hib / Hep B | |
| 3rd Diphtheria, Tetanus, Pertussis (Whooping Cough) / Polio / Hib / Hep B | |
| 1st Rotavirus | |
| 2nd Rotavirus | |
| 1st Meningitis B | |
| 2nd Meningitis B | |
| 3rd Meningitis B | |
| 1st Meningitis C | |
| 2nd Meningitis C (if applicable) | |
| 3rd Meningitis C (if applicable) | |
| 1st Pneumococcal conjugate | |
| 2nd Pneumococcal conjugate | |
| 3rd Pneumococcal conjugate | |
| Other Pneumococcal (if applicable) | |
| Hib / Meningitis C | |
| 1st Measles, Mumps, Rubella (MMR) | |
| Booster Diphtheria, Tetanus, Pertussis (Whooping Cough) / Polio / Hib | |
| Booster Measles, Mumps, Rubella (MMR) | |
| BCG | |
| Details of any other immunisations: | |

I have read and understood this form, and completed it honestly and to the best of my knowledge on behalf of the child mentioned:

| | | | |
|---|---|---|---|
| **Name (print)** | | | |
| **Signature:** | | | |
| **Relationship to child:** | | **Date:** | |

# 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 | |
| English | |
| Welsh | |
| Northern Irish | |
| British | |
| Irish | |
| Gypsy/Traveller | |
| Polish | |
| **Any other white ethnic group, please specify below:** | |
| | |

| **B. Mixed or multiple ethnic groups** | |
|---|---|
| Any mixed or multiple ethnic group | |

| **C. Asian, Asian Scottish, or Asian British** | |
|---|---|
| Pakistani, Pakistani Scottish, or Pakistani British | |
| Indian, Indian Scottish or Indian British | |
| Bangladeshi, Bangladeshi Scottish, or Bangladeshi British | |
| Chinese, Chinese Scottish, or Chinese British | |
| **Other Asian, please specify:** | |
| | |

| **D. African** | |
|---|---|
| African, African Scottish, or African British | |
| **Other African, please specify:** | |
| | |

| **E. Caribbean or Black** | |
|---|---|
| Caribbean, Caribbean Scottish, or Caribbean British | |
| Black, Black Scottish, Black British | |
| **Other Caribbean or Black, please specify:** | |
| | |

| **F. Other ethnic group** | |
|---|---|
| Arab | |
| **Other, please specify:** | |
| | |

| | |
|---|---|
| If you would prefer not to provide this information, please tick here: | |
| If you don't know your ethnicity, please tick here: | |