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 6 TO 11 YEAR OLDS)

TITLE:		**FIRST NAME:**	
SURNAME:			
DATE OF BIRTH:		**GENDER:**	M ☐ F ☐ (please tick)
ADDRESS (incl flat no):		**WHO ELSE LIVES IN THIS HOUSEHOLD?**	(pleases include age and relationship to child)
		IS YOUR CHILD THE LONE OR PARTIAL CARER FOR SOMEONE? If yes, please specify:	YES ☐ NO ☐ (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 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) :

Condition	Response	Condition	Response
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 they used their 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)

Condition	Response				
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?

Service		
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:

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:	