**NEW PATIENT QUESTIONNAIRE - <16 years old**

**Please complete the following clearly and tick the boxes where necessary**

**FIRST NAMES:** …………………………………………………………………………

**SURNAME:** …………………………………………………………………………………

**DATE OF BIRTH (DD/MM/YY):** ………………………………………………

**NAME OF PARENT(S)/GUARDIAN(S):** ………………………………...............................................................…………………

**SMS TEXT MESSAGING – I AGREE TO BE CONTACTED VIA SMS TEXT MESSAGING (for e.g. appointment reminders) AGREE**  **DECLINE**

**MOBILE NUMBER TO BE USED:** ………………………………………………

**IF YOUR FIRST LANGUAGE IS NOT ENGLISH, PLEASE STATE FIRST LANGUAGE:** ………………………………………………

**Do you require an interpreter during appointments? YES  NO**

**PLEASE GIVE DETAILS OF ANY SERIOUS OR ONGOING HEALTH PROBLEMS AND INCLUDE DATES**:……………………

…………………………………………………………………………………………………........................................................................……  
  
…………………………………………………………………………………………………………………………………………………………………………...

**ARE YOU ON ANY CURRENT MEDICATION? YES  NO**

***If yes please list below (please include prescribed and bought medicines and herbal remedies):***

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

……………………………………............................................................................................................................................

…………………………………………………………………………………………………………………………………………………………………………..

Name of Pharmacy for prescriptions to be sent to……………………………………………………………………………………………

**LIST ANY KNOWN ALLERGIES/ REACTIONS TO MEDICINES**. If known state the date allergy started:

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

…………………………………………………………………………………………………………………………………………………………………………..

**CURRENT SCHOOL ATTENDED:** …………………………………………………………………………………………………………………….

**DO YOU SMOKE? YES  NO  If yes, do you smoke: Tobacco  or E-cigarettes**

**DO YOU DRINK ALCOHOL? YES  NO  If yes, how many units per week:** ……………………………

**ARE YOU A CARER?** Do you look after someone **frail, elderly or disabled**? (Not through work)

**YES  NO  If yes, please state who you look after and why:** ………………………………………………….

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

**FOR UNDER 5 YEAR OLDS ONLY:** IMMUNISATION HISTORY -**or provide copy of Red Book**

|  |  |  |  |
| --- | --- | --- | --- |
| **TYPE** | | **DOSE** | **Date Given** |
| DTap/IPV/Hib/HepB  DTap/IPV/Hib/HepB  DTap/IPV/Hib/HepB | | 1ST DOSE  2ND DOSE  3RD DOSE |  |
| DTaP/IPV | | 4THDOSE/BOOSTER |  |
| Rotavirus | | 1ST DOSE  2ND DOSE |  |
| Pneumococcal | | 1ST DOSE  2ND DOSE |  |
| Meningitis B | | 1ST DOSE  2ND DOSE  3RD DOSE |  |
| MMR | | 1ST DOSE  2ND DOSE |  |
| HiB/MenC | |  |  |
| Flu Vaccine |  |  |
| **OTHER e.g. HepB, BCG etc (Please list below) :** |  |  |

**Questionnaire completed by:** …………………………………………………………………………………………………………………….

**Relationship to patient:** …………………………………………………………………………………………………………………….

***OFFICE USE ONLY***

***IMMUNISATION DETAILS LOGGED******NAME: DATE:***

|  |  |
| --- | --- |
| *What Proof of Identity was shown?* |  |
| *What Proof of Address was shown?* |  |
| *Copy of red book taken* | *Y/ N* |
| *KIS activated on Vision* | *Y/ N* |
| *Reception Initials : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
|