**NEW PATIENT QUESTIONNAIRE (C H I L D)**

**This form must be completed in English**

**DATE:**

**PERSONAL DETAILS**

|  |  |
| --- | --- |
| Surname |  |
| First name(s) |  |
| Date of Birth | **DAY: MONTH : YEAR:** |
| Edinburgh address & postcode  (**must include flat number**) |  |
| UK mobile |  |
| Landline |  |
| Email address |  |
| Gender | Male □ Female □ Prefer not to say □  Other (please state) \_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| What School are you currently at? |  |
| What Schools have you previously been at? |  |
| Previous GP? |  |
| Previous Health visitor/ School Nurse |  |
| Are any other people involved in looking after you? If yes please give details of who they are and relationship |  |

**Next of Kin details:**

|  |  |  |
| --- | --- | --- |
|  | **Mother** | **Father** |
| **Name** |  |  |
| **Date of birth (Day/Month/Year)** |  |  |
| **Address if different from child’s** |  |  |
| **Telephone** |  |  |
| **e-mail** |  |  |

**Name of primary carer ………………………………............................................................**

**Name of person with parental responsibility ………………………………........................**

**MEDICAL HISTORY**

**Allergies**

|  |  |
| --- | --- |
| Do you have any allergies to drugs or medicines? If yes, please list below: | Yes □ No □ |
| Do you have to carry an adrenaline pen for allergies? | Yes □ No □ |

**Please List any other significant health problems or operations**

|  |  |
| --- | --- |
| Date | Diagnosis |
|  |  |

**CARERS**

|  |
| --- |
| Do you act as a regular carer for anyone? Yes □ No □ |

**ETHNICITY**

|  |  |  |
| --- | --- | --- |
| Which of these best describes your ethnic group?  Choose **ONE** section **A to C,** then tick the appropriate box to indicate your ethnic group. | | |
| **A: White** [ ] British  [ ] Irish  [ ] Scottish  [ ] Any other white background, please state …………………… | **B: Black**  [ ] Black Caribbean  [ ] Black African  [ ] Black, other, non-mixed origin  [ ] Black British  [ ] Black West Indian  [ ] Black Guyana  [ ] Black North African  [ ] Black Arab  [ ] Black Iranian  [ ] Black – other African country  [ ] Black East African Asian  [ ] Black Indo-Caribbean  [ ] Black Indian sub-continent  [ ] Black – other Asian  [ ] Black – other, mixed | **C: Other ethnic group**  [ ] Indian  [ ] Pakistani  [ ] Bangladeshi  [ ] Chinese  [ ] Greek  [ ] Greek Cypriot  [ ] Turkish  [ ] Turkish Cypriot  [ ] Other European, please state…………………  [ ] Irish traveller  [ ] Other ethnic group  [ ] Traveller – gypsy  [ ] Arab |

**If you prefer not to answer,** **please tick here** □

**University Health Service**

**Practice Consent Form**

**To be completed by Childs Guardian**

**Why We Require Consent**

As part of your medical care we often require to share your clinical information with other services, e.g. Out of Hours Service, Hospitals, Community services and the Ambulance Service. This can be on an emergency or on going basis to facilitate your care and where this is necessary we will share appropriate, relevant and proportionate personal information, in compliance with the law. These organisations need to be fully aware of your medical history and any suggestions we have for your care in the event you become unwell. To share this information, we require your consent so **please note we do not share this information with any other body other than these essential healthcare providers. If we do not have your consent to contact you then this will affect our ability to provide you with a full health care cover service. During the Covid outbreak it is even more essential that we can contact you quickly by various contact routes so please consider this carefully when you answer the following questions on both pages:-**

1. Do you consent to the practice sharing your medical information with emergency services and hospital/community services? YES NO
2. Do you consent to the practice sharing your medical information with the Out of Hours Service? YES NO
3. Name
4. Mobile telephone number
5. Email address
6. Date of Birth DD/MM/YYYY

Signature .............................................. Date .........................................

**Please note that you can opt out of any of the above services at any time by contacting us on 0131 650 2777 or writing to the Practice Manager at the practice address.**

**Online Registration and Text Messaging Services**

Online registration allows you to:

* Book a routine GP appointment 24 hours per day, 7 days per week through the year
* Cancel appointments that are no longer required
* Check your medication and order repeat prescriptions
* Amend your mobile phone number and email address where appropriate

Text messages allow the practice to send you health promotional information, appointment reminders and information on flu clinics. Please speak to Reception staff if you would like to register for this service.

**It is extremely important that we are able to contact you regarding your health care** and from experience it is useful to be able to do this in a variety of ways such as phone, mail, email and texting. Please consider carefully before saying No to any of the options as this may make contacting you about your health care difficult. In line with GDPR regulations we do require your consent for the practice to contact you by the various methods outlined below so please answer the questions below:-

1. I consent to the practice contacting me by text SMS YES NO
2. I consent to the practice contacting me by email YES NO
3. I consent to the practice contacting me by post YES NO
4. I consent to the practice contacting me by telephone YES NO
5. Name
6. Mobile telephone number
7. Email address
8. Date of Birth DD/MM/YYYY

Signature............................................... Date ..................................

**Please note that you can opt out of any of the above services at any time by contacting us on 0131 650 2777 or writing to the Practice Manager at the practice address.**