**New Patient Questionnaire – Child (Under 18)**

*Welcome to Neetside Surgery. Please take a few moments to fill out this questionnaire. The information we collect is* ***strictly confidential*** *and is used to ensure that we can provide the best care for you. It would help us greatly if you could fill in both sides and all questions are answered. Thank you. The Neetside Surgery Doctors*

***Please provide proof of ID when returning the completed forms e.g birth certificate***

**Personal Details**

Name……………………………………… DOB……................... Home Tel No. ………… Mobile NO. ……………

Next of Kin……………………… Relationship to patient……………................ Next of kin contact no. …………….

Gender (please let us know if different from birth)……………………….Ethnic Origin…………… Height…………Weight……………… Occupation / Place of education ……………………………

**Please chose your preferred Chemist**

Prescriptions: My preferred chemist for prescriptions to be sent to is ………………….…………………...

(Bude Pharmacy, Boots, Belle Vue Chemist or Stratton Pharmacy)

All above chemists use electronic prescribing (EPS) please tick the box if you are happy to use this service 🞎

**Summary Care Record**

**This gives your consent for authorised NHS staff to see your medication and allergies (and in the future your basic medical history)**

**YOU MUST SELECT ONE FROM THE LIST BELOW**

Express consent for medication, allergies and adverse reactions only 🞎

\*Express consent for medication, allergies, adverse reactions AND additional information 🞎\* (recommended)

Express dissent (Opt out) 🞎

**LIVI DOCTORS – available by downloading the LIVI APP (Over 2’s only)**

This gives you access to an NHS GP for medical advice, prescriptions and referrals.

In order for Livi to access your records, you will need to give express consent for record sharing (above)

**Carers/Carees**

Are you a carer for a relative, friend or neighbour? Y 🞎 N🞎 If yes, who do you care for?……………………………

Are you being cared for by a relative, friend of neighbour? Y 🞎 N🞎 If yes, Name of carer?…………………………

Do you or your carer have any information or communication needs relating to a disability, impairment or sensory loss? Y 🞎 N🞎 If yes, do you have any special requirements? (Larger writing, brail etc)

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

**Specific Needs:** Please detail any specific needs you have so the Practice can ensure they are identified and accommodated:

Please state any sensory impairment you may have: Speech🞎 Hearing 🞎 Sight 🞎

Are you an ‘Assistance Dog’ user? Yes 🞎 No 🞎

Please state any Physical Disabilities you have: ……………………………………………………..……….……..

Please state any Mental Disabilities you have: ……………………………………………………….…….……….

Please state any requirements you have to be able to access the Practice Premises:………………….……………..

Please state any Religious or Cultural needs: ……………………………………………………….….……………   
Do you require the help of a Translator/Interpreter: ……………………………………………….………………...

**Medical History** (Please record any current or previous major illness, health problems or operations)

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

**Referrals**

Are there any investigations/referrals outstanding from your previous GP? Yes 🞎 No 🞎  
If yes please provide additional information …………………………………………………………………………….

**Medication** Current medication (If possible please provide a previous repeat prescription - we can take a copy)

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

**Allergies**……………………………………………………………………………

**Family History**

Is there a close **family history** of any of the following illnesses?

Stroke………… High blood pressure……........ Heart Disease…………… Diabetes………………………  
Other (please specify) …………………………… None / unknown 🞎

**Exercise**   
What do you do for exercise and how often?

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

**Smoking:** Are you a smoker? Current 🞎 Ex Smoker 🞎 or Never Smoked 🞎

**Current Smoker**……………cigs/day Would you like help to stop? YES🞎 NO 🞎

**Ex Smoker**………..cigs/day When did you stop?............................

**Females only:**

What form of contraception do you currently use? ……………………………………………………………..

**Outside the UK:** (Please provide a copy of your medical records from abroad where applicable)

Is this your first time registering in the UK? Yes 🞎 No 🞎  
If YES, what date did you arrive in the UK? ……………………

If No, please provide your previous address in the UK and the dates you where out of the UK……………….

…………………………………………………………………………………………………………………... **CONSENT FORM TO RECEIVE TEXT AND EMAILS FROM**

**NEETSIDE SURGERY**

**Full Name:** …...………………………………………………..….  **Date of birth:** ………………..……….

**Mobile no:** …………………………………..………….………… **Landline** ………………………………

**Email address:** …………………………..…………………………………….……………………………….

I give my consent to receive text message reminders from the surgery YES ⎕ NO ⎕

I give my consent to receive emails from the surgery YES ⎕ NO ⎕

Preferred method of written contact: Letter ⎕ Email ⎕ Text Message ⎕

**PARENT OR GUARDIAN DECLARATION**

I can confirm that, to the best of my knowledge, the information I have provided is accurate and correct.

Print name ………………………………………….…

Signed …………………………………………….......

Relationship to Child …………………………………

Date ………………………………..

(Please hand in at reception when completed)