**7.** The information below may be important in identifying cause & prevalence of conditions which vary according to ethnicity and ensuring services are shaped to best meet the individual needs of all our patients.

**ETHNICITY**

This information may be important in identifying cause & prevalence of conditions which vary according to ethnicity. Tick one box to indicate your ethnic group:

White Black Caribbean Indian

White British Black African Pakistani

White Irish Other Black background Bangladeshi

Other ethnic group Chinese

Do not wish to state ethnicity Other Asian background

**GENDER**

Which of the following options best describes how you think of yourself?

Woman (including trans woman) Man (including trans man)

Non-binary In another way Don’t want to say

Is your gender identity the same as the gender you were given at birth?

Yes No Don’t want to say

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Working together** Thank you; we will review the information provided and may contact you to provide health promotion advice or consultation if needed. Please sign to acknowledge your understanding & agreement to use our services as set out in our Practice leaflet:

Signed:

Please return this form to reception along with the GMS1 form, confirmation of parental responsibility & a list of repeat medication.

NEW PATIENT QUESTIONNAIRE FOR YOUNG PEOPLE AGED 0-17

Please answer each question for the young person, as fully as you can. If you need help filling in this sheet, just ask one of our staff. This confidential information will be stored electronically & shared only for healthcare purposes.

Please return this form to reception along with your GMS1 registration form, confirmation of parental responsibility & a list/re-order slip of repeat medication. If possible, please ensure the NHS number is recorded.

Office: ID checked/NHS number: Address checked: Rpt Rx appt:

1. **YOUNG PERSON’S DETAILS Date form completed:** \_\_\_\_\_\_\_\_\_\_\_

Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Forenames: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

All Previous Surnames: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact number for 0 – 13 year old (**parent’s** number): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact number for 14 – 17 year old (**child’s number**): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We offer automatic text messaging for appointment & review reminders, please indicate your consent to this: [ ] **yes please**; no thanks [ ]

Email address: (child)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We will use your email address to send you practice communications & referral information, please indicate your consent to this: [ ] **yes please**; no thanks [ ]

Emergency contact name & number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & relationship of those with parental responsibility:

Do any other adults live in the family home? If so, who:

Are there any special information or communication needs? YES/NO

Please state what these are eg text relay service/SMS/email:

If interpreter is needed, please state language:

1. **YOUNG PERSON’S CURRENT STATE OF HEALTH** answer each line

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you ever been diagnosed with:** | No | Yes | Tick below if you are **currently** taking medication for this**\*\*** |
| Asthma |  |  |  |
| Cancer |  |  |  |
| COPD |  |  |  |
| Depression |  |  |  |
| Diabetes |  |  |  |
| Epilepsy |  |  |  |
| Glaucoma |  |  |  |
| Heart disease |  |  |  |
| Hypothyroidism |  |  |  |
| High blood pressure |  |  |  |
| Mental health |  |  |  |
| Rheumatoid arthritis |  |  |  |
| Stroke/TIA |  |  |  |
| Learning disability |  |  |  |
| **Please list any other serious or chronic illnesses, operations or disabilities**: | | | |

**l**

**\* please attach a copy of the current medication re-order slip**

If the young person is currently taking prescribed medication, you will need to **book an appointment with our practice pharmacist in the next 5 – 10 days** & before you need your first prescription from us. We like patients to order their medication directly with us, so please download the NHS app or bring formal photo ID to this appointment so we can set up online ordering for you.

**YOUNG PERSON’S ALLERGIES**

Do you suffer from any **allergies** or have had a reaction to any medication?

NO YES - please list these here:

1. **CHILD IMMUNISATIONS – FOR THOSE VACCINATED ABROAD**

It is **essential you provide us with a copy of your child’s immunisation history given in another country, with this completed form**, so that the Practice Nurse can review and update their medical records & invite them to have any vaccinations due under the UK NHS vaccination programme: www.gov.uk/government/publications/routine-childhood-immunisation-schedule

1. **ABOUT THE YOUNG PERSON:**

Their school and address:

Have they ever been a “a looked after child”? NO/YES

Family social worker details if applicable:

Are they a carer? NO/YES

(ie do they care for a parent/relative/friend on an unpaid basis?)

#### YOUNG PERSON’S LIFESTYLE HABITS –please complete each section

## Height (cms): Weight (kg):

**Exercise:** - number of times per week engaged in 30mins+ moderate activity? \_\_\_

**Smoking Status**:

Never smoked tobacco Ex-smoker: I gave up in (year) \_\_\_\_\_\_

Current Smoker - I currently smoke \_\_\_\_\_\_\_\_/day

Please book an appointment with our HCA for smoking cessation advice

1. **YOUNG PERSON’S FAMILY HISTORY**

If any of their immediate family were diagnosed with any of these illnesses **before the age of 60,** please tell us by ticking the appropriate box(es).

If none, tick here

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Mother | Father | Sisters | Brothers |
| Asthma |  |  |  |  |
| Diabetes |  |  |  |  |
| Stroke/TIA |  |  |  |  |
| Heart Disease |  |  |  |  |
| High Blood Pressure |  |  |  |  |