**ST. MARY’S MEDICAL CENTRE – New Patient Questionnaire – Children aged under 16**

Please complete as much of this form as possible to help us understand your current health and future health needs.

|  |  |
| --- | --- |
| First Name(s) |  |
| Surname |  |
| Date of birth |  |
| Home telephone number |  |
| Mobile phone number |  |
| Place / country of birth |  |
| What is your main spoken language |  |
| Will you require an interpreter for appointments? |  |
| What is your ethnicity(eg white British, black Caribbean, Pakistani) |  |
| Name of mother(and address if not living with you) |  |
| Name of father(and address if not living with you) |  |
| Name of school |  |
| Name of Health Visitor (if pre-school) |  |
| Name of School Nurse (if school age) |  |

**Additional information:**

|  |  |
| --- | --- |
| Name of person(s) with parental responsibility for you |  |
| What is this person’s relationship to you (eg, mother, father, foster carer etc. |  |
| Name and contact details of Social Worker (if you have one) |  |
|  |  |

**Smoking history:**

|  |  |
| --- | --- |
| Do you smoke?If yes, how many cigarettes per day? | Yes / No |
| Are you an ex-smoker?If yes, when did you stop smoking? | Yes / No |
| Would you like some information to help you give up smoking? | Yes / No |

**Your medical history:**

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Illness, accident, operation | Date | Illness, accident, operation |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |  |
| --- | --- |
| Do you have any allergies?If yes, to what? | Yes / No |
| Are you currently under the care of a hospital doctor? If Yes, which doctor and where. | Yes / No |

**Your current medication**:

**\*Please bring proof of any medication taken with you to your registration check\***

|  |  |
| --- | --- |
| Medicine name | Strength and dose |
|  |  |
|  |  |
|  |  |
|  |  |

**Vaccination History**

**\*Please bring proof of vaccinations with you when you attend your registration check\***

|  |  |  |  |
| --- | --- | --- | --- |
| Date | Vaccination | Date  | Vaccination |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Family History** – has any member of your immediate family (parents, brothers, sisters) suffered from any of the following:

|  |  |
| --- | --- |
| Heart disease | Who? |
| Diabetes | Who? |
| Stroke | Who? |
| High blood pressure | Who? |
| Cancer (specify which cancer) | Who? |

**PRACTICE USE ONLY**

**NEW PATIENT CHECK LIST**

**PATIENT PRESENTS WITH MEDICAL CARD**

Check in Practice Area [ ]

Name & Address [ ]

Signed and Dated [ ]

**REGISTRATION FORM (GMS1)**

 Check in Practice area [ ]

 Title, surname, Forename & previous surname(s) [ ]

 Date of Birth [ ]

 Town and Country of Birth [ ]

 Previous Address if recently moved [ ]

 Previous GP’s name and address [ ]

If child < 5 check if registering for Child Health [ ]

Check form signed and Dated [ ]

 Patient Access form completed (adults only) [ ]

**IDENTIFICATION REQUIRED – IDEALLY PHOTO ID**

Photo Driving Licence [ ]

 Passport [ ]

 Other (Bus Pass/Student Card [ ]

 Birth certificate [ ]

 Marriage Certificate [ ]

**PROOF OF ADDRESS**

 Recent Utility Bill [ ]

 Council Tax Bill [ ]

 Benefits Statement [ ]

 Other [ ]

 Details

**RECEPTIONIST SIGNATURE**