Riverside Surgery
New Patient Questionnaire for Under 16s

Surname: First Names:

Date of Birth: Place of Birth:

Ethnicity:

Address:

School/Nursery:

Home Telephone Number:

Mobile Telephone Number:
Please indicate who the mobile phone number is linked to i.e. parent

E-mail Address:
Please indicate who the e-mail address is linked to i.e. parent

We may at times need to contact you by telephone, SMS text or e-mail regarding test results or appointments. Please tick and sign below if you give permission for us to leave a message, send a text message (including appointment or review reminders) or send an e-mail.

☐I give permission for the staff at Riverside Surgery to leave a message on my telephone 'asking me to contact the surgery'

☐ I give permission for the staff at Riverside Surgery to send me a text message

☐ I give permission for the staff at Riverside Surgery to send me an e-mail

☐ I understand that it is my responsibility to advise Riverside Surgery of any change in my contact details including mobile telephone number and e-mail address

Signed: Date:

Name of Mother:

Contact Number & Address for Mother:

Name of Father:

Contact Number & Address for Father:

Please give names and dates of birth of any siblings:

Medical History

Have your child had any operations or prolonged stays in hospital? (Please give details)

Family History

Has anyone in the family suffered from any of the following conditions? If so, which family member?

☐Asthma:

☐Diabetes:

☐Heart Disease:

☐High Blood Pressure:

☐Cancer (please specify which type of cancer):

Immunisations

If you have your child's red book please bring it into the surgery and we will copy their immunisation record, or please indicate all that apply with dates:

Diptheria, tetanus, pertussis (whooping cough), polio & haemophilus influenza type b (DTaP/IPV/Hib)

☐1st Date:
☐2nd Date:
☐3rd Date:

Pneumococcal conjugate vaccine (PCV)

☐1st Date:
☐2nd Date:
☐3rd Date:

Measles, Mumps & Rubella (MMR)

☐1st Date:
☐2nd Date:

Meningitis C

☐1st Date:
☐2nd Date:

Other (please give details with dates):

Allergies

Does your child have any allergies? ☐Yes (please give details) ☐No

Medication

Please provide us with a copy of your child's repeat medication list from their previous GP (if you do not have this available, please list their medications):

Does your child take any Over-The-Counter Medications? ☐Yes (please give details) ☐No

Would you like to nominate a pharmacy so that we may send prescriptions directly there without you needing to come to collect from us? ☐Yes (please tell us which pharmacy) ☐No

Communication and Access Needs

Does your child have any communication/access needs or requirements?

Does your child need a format other than standard print?

How would you like us to communicate with you?

Can you explain what support would be helpful?

What is the best way to send you information?

Safeguarding

Is your child: (please circle where applicable)

Adopted	Yes	No
Fostered	Yes	No
A looked after child	Yes	No

If you have answered yes to any of the above, please provide copies of court orders and details of parental responsibility.

Named Social Worker: ……..

Named Social Care Agency: ……

Previous GP and Surgery: ……..

Previous Health Visitor: .....

Summary Care Record

If you have not received information previously, please ask at reception for an information pack