MONTGOMERY
MEDICAL PRACTICE
www.montgomerymedicalpractice.wales.nhs.uk

INVESTORS IN PEOPLE

New Patient Child Questionnaire

Registration for Children

Please assist us by completing the following when registering and bring both this and the registration form to the surgery as soon as possible.

Due to the new General Data Protection Guidelines, children aged 13 and over are able to complete their own questionnaire.

Please be aware that if your Child(ren) / Baby are brought in for Immunisations or an appointment, by anyone other than those with parental/ legal guardianship, we will need a signed letter of consent to assess and treat the child by the authorised parental/legal guardian**.**

Childs details

Title: ……Forename(s): ……

Surname ……..NHS number (if known):.....

Date of Birth: ……/……/……

Address:

……..

……Postcode: ...……..……

Home Tel: ……..

Mobile (if aged 16 and over): ……

Gender: ……

Ethnicity

Please tick or circle

Asian, Asian Welsh or Asian British
Indian
Pakistani
Bangladeshi
Chinese
Any other Asian background

Black, Black Welsh, Black British, Caribbean or African
Caribbean
African
Any other Black, Black British or Caribbean background

Mixed or multiple ethnic groups
White and Black Caribbean
White and Black African
White and Asian
Any other Mixed or multiple ethnic background

White
Welsh, English, Scottish, Northern Irish or British
Irish
Gypsy or Irish Traveller
Any other White background

Other ethnic group
Arab
Any other ethnic group

Language preference ……

Parent Information

Name of and date of birth of mother ……..

Name and date of birth of father ……..

Marital status ……

If you are unmarried, please provide a copy of the child's birth certificate in order to ensure appropriate consent is documented for both mother and father.

For "Looked After" children only

If the child is a 'Looked After Child', we will need a copy of the parental/legal guardian document with the completed registration form.

Is the New Patient "Looked After Child" (e.g. a child in care)? **Yes / No**

If a child, who has parental responsibility? ……..

Address of person with parental responsibility ……..

……..

……..

……..

Telephone Number of person with Parental Responsibility ……..

Name of and contact details of Placing Authority ……..

Name and contact details of School …….

Consent

Do you consent to the practice contacting yourself by text message for appointment reminders, invitations to health checks, vaccination reminders, to let you know prescription are ready to collect and anything else relevant to your child's healthcare?

***Yes/No (please delete as appropriate)** **Surgery Code 9Ndp / 9NdQ**

Mobile number : ……

Do you consent for us to correspond with you via email if so please supply us with a preferred e-mail address for this purpose?

***Yes/No (please delete as appropriate)** **Surgery Code 9Nds / 9Ndy**

Email address: ……

Vaccinations

Is the child up to date with all routine childhood immunisations? **Yes / No**
(If possible please provide the surgery with a list of the up-to-date vaccinations).

Previous Serious Illness

Has the child have ever had any surgical operations? please list them below:

Has the child had any serious accidents or injuries? please list them below:

Carers in Practice

A Carer is someone who looks after a relative, neighbour or friend who cannot manage on their own. **If the child is a carer** please answer the following.

- Who they care for? ……
- What is their relationship to the child? ……
- Would you like more information about services for patients who are carers?
- (If yes, you can ask at reception) Yes / No

Family History

Is there any of the following in your family *(father, mother, brother, sister)* before the age of 65?

Heart Disease? *Yes* / *No* which family member? ……..

Stroke? *Yes* / *No* which family member? ……..

Cancer? *Yes* / *No* which family member? ……..

Site of cancer? ……

MONTGOMERY MEDICAL PRACTICE

New Patient Medication Questionnaire (Any medication please complete the table below)

- Name of Patient:
- Date of Birth:
- Address:
- Name and address of previous GP: ……

Name of Drug	Tablets or medicine	Strength or dose	How many times a day?	Reason for medication	When did you start taking?

Please attach a copy of your Repeat Prescription Slip from your old doctor's surgery. We will NOT be able to issue your repeat medication without this.

Surgery Use: Please scan completed form with allergies and give original to the Dispensary.

The Surgery | Well Street | Montgomery |SY15 6PF | **T**: 01686 668217 | **E:** W96001.enquiries@wales.nhs.uk
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Allergies (IF ANY)

Are you allergic to any drugs/ non drugs (e.g. peanuts/wasps) or have you experienced any side effects from any drugs? Please list below:

Name of drug/non drug that caused allergy ……..

Type of allergy (e.g. rash etc) ……..

Name of drug/non drug that caused allergy ……..

Type of allergy (e.g. rash etc) ……..

Name of drug/non drug that caused allergy ……..

Type of allergy (e.g. rash etc) ……..

Drugs known to cause you side effects (IF ANY)

Name of drug that caused side effect ……

Type of side effect (e.g. vomiting, diarrhoea etc) ……

Name of drug that caused side effect ……

Type of side effect (e.g. vomiting, diarrhoea etc) ……

Name of drug that caused side effect ……

Type of side effect (e.g. vomiting, diarrhoea etc) ……

If you have a food intolerance please list here ……

Notes

Thank you for completing this questionnaire

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