New Patient Health Questionnaire
Hampstead Group Practice
(Children aged 0-15 years)

Thank you for joining Hampstead Group Practice. To ensure that we have up to date medical and personal details, please complete this registration questionnaire as fully as possible. If you have problems completing any section please ask for assistance. You may attach a separate sheet if you wish to give us any further information

The information you give is confidential and is subject to the Data Protection Act

Personal Details

Surname: ……. Forename/s: ……...

Previous surname: (if any): …….. M/F

Title (Mr/Master/Miss) ……. D.O.B ……...

Address (inc. flat number) : …….....

Post code: ……

Telephone number (and area code) Home:

Mobile: ……. Fax: ……..

Religion: ……..

To which ethnic group does your child belong? (Please tick box)

(White) ☐White British ☐Irish

(Mixed) ☐White & Black Caribbean ☐ White & Black African ☐ White & Asian

(Asian) ☐Indian ☐Pakistani ☐Bangladeshi

(Black) ☐Caribbean ☐African

(Chinese) ☐Chinese

(Other) Please write in: ……

Please give Country of Birth: ……....

Main language spoken if not English: ……....

When seeing the Doctor or Nurse will you/she/he require an interpreter? **Yes/No**

Next of Kin

Mother's surname: …… Forename: ……..

Father's Surname: …… Forename: ……

Are the parents married to each other? **Yes / No**

Do both parents live at the same address? **Yes / No**

Guardians name (this may or may not be a parent and will have been awarded in court)

Surname: …… Forename: ……

Guardian's relationship with child? ……

Next of Kin / Guardians Telephone Number:

Home: …… Work: ……

Mobile: …… Fax: ……

General Details

What type of accommodation do you live in? House/Flat/Hostel (Other please specify)

……..

Which Nursery/School/College does your child attend? ……

Does anyone living in the same household smoke? **Yes/No**

Is/was your child breast or bottle-fed? ……..

Does your child eat a varied, balanced diet? **Yes/No**
If not, please give details: ……

Does your child eat a particular diet? **Yes/No** If 'yes' please give details.
Vegan/ Vegetarian/ Low fat/ Low salt/ Gluten free (Other please specify):

……..

Does your child take regular exercise? (At least 30 minutes x 3 per week) **Yes/No**

Is your child or anyone else in the household registered disabled? **Yes/No**
If 'yes' please give disability: ……

Is your child a main carer? **Yes/No** If 'yes' who for? ……..

Health Details

It is very important that we have an up to date record of your child's vaccinations. Please fill in the chart below, or bring your child's Health Record Book to the surgery for us to record the details

Vaccination Record				
Vaccine names	1st * (aged 2 months)	2nd * (aged 3 months)	3rd * (aged 4 months)	Place given GP/Clinic/Abroad
BCG (any age)				
Diphtheria, Tetanus, Pertussis, Polio, Hib *				
Meningitis C (3 doses 2-4 months) *				
Meningitis C (2 doses 5-11 months)				
Meningitis C (1 dose 1-5 years)				
MMR (aged 1 year)				
Pre-School Boosters (aged 3-5 years)				
Diphtheria, Tetanus, Pertussis, Polio				
MMR				
Pre-Leaving School Boosters (aged 13-16 years)				
Diphtheria, Tetanus, Polio				

Does your child have any allergies (cats, dogs, eggs etc) or have you been told that he/she is allergic to any medications? (E.g. aspirin, penicillin) **Yes/No**
If 'yes' please list: ……..

Has your child had any medical problems in the past needing hospital, surgery attendance or repeated visits to the doctor? **Yes/No**
If 'yes' please list with dates: ……...

Does your child have any current illnesses for which she/he is receiving treatment? **Yes/No**
If 'yes' please give details: ……...

Is your child taking any prescribed medication/tablets? **Yes/No**
If 'yes' please list giving dose and frequency, or attach the repeat part of their last prescription:
……...

Please give your child's:

Height: ……. **Weight: …….**

Urine sample given (Please tick box) ☐

Family History

Is there a first-degree family history of?	Yes/No	First-degree family members are mother/father/brother/sister	Age when first diagnosed
Heart attack/ Angina/ By-pass surgery etc			
High blood pressure			
CVA/Stroke			
Diabetes			
Asthma/COPD			
Cancer			
If 'yes' please give details where was the cancer etc?			
Severe allergies			
If 'yes' please give details:			

If your child is over 5 years, we will be pleased to offer him/her a registration appointment with a nurse where you/he/she can discuss any health issues.

I have **Accepted** / **Declined** (Please circle/delete) the offer of a New Patient registration appointment for my child.

Date …… Signed ……

For Office Use Only	
Two items of proof of residency	**[ ]**
Form checked and fully completed	**[ ]**
Practice leaflet and Health Information pack given	**[ ]**
Date……	
Receptionist's Initials……	