HILLVIEW MEDICAL CENTRE

NEW PATIENT QUESTIONNAIRE FOR PATIENTS AGED 16 AND UNDER & REGISTRATION FORM

PERSONAL DETAILS:	
Title	
Surname	
Forename	
Middle Name(s)	
Date of Birth	
NHS Number	
Gender	
Marital Status	
Previous Surname(s) (where applicable)	
Town & Country of Birth	
Ethnicity	☐ British ☐ African ☐ Bangladeshi ☐ Caribbean ☐ Chinese ☐ Indian ☐ Irish ☐ Other White ☐ Other Asian ☐ Other Black ☐ Other Mixed ☐ White Asian ☐ Pakistani ☐ W&B African ☐ W&B Caribbean ☐ Refuse to Divulge
Main Language	
Interpreter Required?	☐ Yes ☐ No
HOME ADDRESS:	
House Name\Flat Number	
Number & Street	
Locality	
Town	
County	
Postcode	
CONTACT DETAILS:	
Home Telephone	
Mobile Telephone	
Email Address	
PATIENT CONTACTS:	
Next of Kin	
Relationship	
Telephone Number	

PLEASE HELP US TRACE YOUR PREVIOUS MEDICAL RECORDS BY PROVIDING THE FOLLOWING:	
Previous address in the UK	
Name & Address of previous GP	
IF YOU ARE FROM ABROAD:	
Your first UK address where registered with a GP	
If previously resident in UK; date of leaving	
Date you first came to live in the UK	

HILLVIEW MEDICAL CENTRE

NEW PATIENT QUESTIONNAIRE FOR PATIENTS AGED 16 AND UNDER & REGISTRATION FORM

MEDICAL HISTORY:

If under 5:

Type of birth (e.g. natural,Caesarean)	
Birth weight (if known)	
Feeding (e.g. breast or bottle)	

Please note all details of children under 5 are passed to the Health Visiting Team for Child Health Surveillance

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details: (please continue on separate sheet if needed)

Condition	Year Diagnosed	Ongoing?
		☐ Yes ☐ No
		☐ Yes ☐ No

Have any close relatives (mother, father, sister, brother) ever suffered from:

☐ Heart Disease / Angina	☐ Diabetes	☐ Epilepsy
☐ High Blood Pressure	☐ Stroke/TIA	☐ COPD
☐ Asthma	☐ Cancer	☐ Hypothyroidism
☐ Osteoporosis	☐ Rheumatoid Arthritis	☐ Dementia
☐ High Cholesterol	☐ Other (please state):	

Does your child have any allergies?(e.g. antibiotics, food, bee sting, latex,) ☐ YES ☐ NO

If Yes please state:

Immunisations; If known, please circle the immunisation received and complete the date received;

	Date Received		Date Received
Whooping Cough		Polio	
Tetanus		HiB	
Measles		MMR	
BCG (TB)		Meningitis	
Booster: Tetanus		Booster: Polio	
Booster: Diptheria		Booster: MMR	

HEALTH INFORMATION:

Weight (if known) (st\lbs or Kgs)		Height (if known) (ft\" or metres)	

CURRENT MEDICATION:

If you have a repeat medication slip from your previous GP please attach to this form.

PRACTICE SERVICES\GROUPS:

Young Carers: If you are a Young Carer would you like to be added to the Practice's register to receive regular information and support ☐ YES ☐ NO

(If yes) I care for (name):

Relationship to you:

The person I care for has:	☐ Dementia	☐ Physical Disability	☐ Mental Illness	☐ Chronic Disease ☐ Other

Identifying Patients with Disabilities and other needs - Are you:

registered blind ☐ partially sighted ☐ registered deaf ☐ registered deafblind ☐ on the learning disabilities register ☐ have a visual impairment ☐ have hearing difficulties ☐ or use a hearing aids ☐

Do you have any information or communication needs when attending the surgery or receiving calls and

letters from us?

Are you happy for these requirements to be shared with other healthcare professionals? Yes ☐ No ☐

Electronic Prescription Service: The practice can now send your prescription to your preferred pharmacy electronically. If you have previously nominated a pharmacy in another area and you now wish to change to a local pharmacy, please inform us of your preferred pharmacy:	

If any of the details on this form change in the future please inform us.
Please note that unless we are informed otherwise the contact numbers provided on this form will remain on the listed patient's record after they turn 16. Therefore we advise that the records are updated after the Childs 16th birthday to provide full confidentiality.

Name of person signing on behalf of Patient:	
Relationship to Patient:	
Signed:	
Date:	

Should you require any further information about the Practice please refer to the Practice Website: www.hillviewmedicalcentre.com or speak to Reception.