

SUMMERTOWN GROUP PRACTICE

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For surgery use only
Rec'd by _____
Inform reg GP? _____
EMIS no _____
Reg by _____

CHILD REGISTRATION QUESTIONNAIRE - PART 2 0 – 16 years old

This information will help us to provide you with the best care until your full medical records are received. Please hand it to the receptionist when completed.

Title and Last Name	
ALL Forenames	Any previous names
Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth
Address	
Parents/Guardians names & addresses	
Mother:	Father:
Do you have parental responsibility? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have parental responsibility? Yes <input type="checkbox"/> No <input type="checkbox"/>
Home Tel No:	Parent's Tel Nos (mobile and work)
Present School	
MEDICAL HISTORY Year	Illness/accident/operation (please include physical and nervous conditions and important disabilities)
Is your child under medical care of any sort? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe	
Does your child suffer from any allergies? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe	
Does your child take any regular medication? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please describe	

Aged 14 – 16 only

Do you smoke? Yes No Never Smoked Ex-smoker Date stopped _____

If yes, would you like help to stop? Yes No

Age Vaccine Usually Given	Disease		Have you been given this vaccine?	If YES, dates given
3 times in First Year of Life	Diphtheria / Tetanus / Polio / Pertussis (DTP or 'Triple') / HIB	1 st Dose	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
		2 nd Dose	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
		3 rd Dose	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
3 times in 13 months of Life	Prevenar (pneumococcal)	1 st Dose	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
		2 nd Dose	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
		3 rd Dose	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
2 times in First Year of Life	Rotavirus	1 st Dose	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
		2 nd Dose	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
2 times in First Year of Life	Men C	1 st Dose	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
		2 nd Dose	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
		3 rd Dose	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
13 months	Hib/Men C		Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
13 months	Measles, Mumps, Rubella (MMR)	1 st Dose	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
Pre-School MMR		2 nd Dose	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
Pre-School DTP	dTaP/IPV (Diphtheria, Tetanus, Polio & Pertussis)		Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
14 years	Td/IPV		Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
	Men C		Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	

Any other vaccinations

Disease	Have you been given this vaccine?	If YES, dates given
HPV (Gardasil)	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
Heaf Test & BCG (for TB)	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
Hep A	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
Hep B	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
Chicken Pox	Y <input type="checkbox"/> N <input type="checkbox"/> Unknown <input type="checkbox"/>	
OTHER VACCINATIONS:		

ETHNIC GROUP DATA COLLECTION - STRICTLY CONFIDENTIAL

The Health Service needs to know the ethnic group of patients for the purpose of planning. This is to make sure that all sectors of the community have equal access to the services provided. Ethnic group describes how you see yourself, and is a mixture of culture, religion, skin colour, language, the origins of yourself or your family. **It is not the same as nationality.** The information given will be treated in the strictest confidence.

The information is used only by National Health Service Staff and will not be passed on to other agencies, or used for any other purposes.

<input type="checkbox"/> White – British	<input type="checkbox"/> White – Irish	<input type="checkbox"/> Any other White	<input type="checkbox"/> Mixed – White and Black Caribbean	<input type="checkbox"/> Mixed – White and Black African
<input type="checkbox"/> Mixed – White and Asian	<input type="checkbox"/> Any other mixed background	<input type="checkbox"/> Indian	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Bangladeshi
<input type="checkbox"/> Any other Asian background	<input type="checkbox"/> Black – Caribbean	<input type="checkbox"/> Black – African	<input type="checkbox"/> Any other Black background	<input type="checkbox"/> Chinese
<input type="checkbox"/> Any other Ethnic Group		<input type="checkbox"/> Do not want to give Ethnic Group		