**NEW CHILDREN UNDER 16 PATIENT QUESTIONNAIRE**

**DATE:** ……………………………….. **FEMALE/MALE**

**SURNAME:** ……………………………………………… **FIRST NAMES:** ……………………………………………………………………………….

**ANY PREVIOUS SURNAME** …………………………………………………………………………………………………………………………………

**ADDRESS:** ……………………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………………...

**TELEPHONE: HOME** ……………………………………………………………. **MOBILE**  …………………………………………………………….

**EMAIL:** ……………………………………………………………………………………………..

**WHO DO THESE DETAILS BELONG TO? (e.g mum, dad etc)** ………………………………………………………………………………

**CAN WE LEAVE A MESSAGE ON: HOME/MOBILE TEXT MESSAGE: YES/NO**

**PERSON WITH PARENTAL RESPONSIBILITY: NAME: ……………………………………………………………………………………**

**RELATIONSHIP : ………………………………………………………………….. CONTACT NUMBER: ………………………………………**

**WHO ELSE LIVES IN THIS HOUSEHOLD: MUM DAD STEP PARENT PARENT’S PARTNER**

**GRANDPARENTS BROTHERS AND SISTERS HOW MANY? FOSTER CARER GUARDIANS**

**OTHERS – PLEASE STATE** …………………………………………………………………….

**NEXT OF KIN: - NAME:** ……………………………………………… **PHONE NUMBER:** ……………………………………………………

**RELATIONSHIP TO YOU: (e.g daughter)** ……………………………………………………………………………………………………………

**DOES YOUR CHILD CARE FOR ANYONE?** ………………………………………………………………..

**DETAILS OF THE PERSON THIS CHILD CARES FOR:** …………………………………………………………………………………………

**ADDRESS/CONTACT NO’S:** …………………………………………………………………………………………………………………………………

**MAIN LANGUAGE SPOKEN:** ………………………………………………………. **INTERPRETER NEEDED:** YES/NO

**PERSONAL MEDICAL HISTORY**

**HAS YOUR CHILD HAD ANY SERIOUS ILLNESS OR OPERATIONS? YES NO**

**YES NO**

**IF YES, WHAT WAS THIS AND WHEN?** ……………………………………………………………………………………………………………..

**DOES YOUR CHILD HAVE A DISABILITY OR CHRONIC CONDITION? YES NO**

**YES NO**

**YES NO**

**IF YES, PLEASE SPECIFY** …………………………………………………………………..

**MEDICATION:**

**IS YOUR CHILD ON ANY REGULAR MEDICATION? YES NO**

**YES NO**

**YES NO**

**ALLERGIES:**

**DO YOU HAVE ANY ALLERGIES TO ANY MEDICATIONS:** YES/NO

**IF YES, PLEASE LIST:** ……………………………………………………………………………………………………………………………………………

**FAMILY HISTORY**

**HEART DISEASE BEFORE AGE 60 YES/NO FAMILY MEMBER:** ……………………………………………

**HEART DISEASE AFTER AGE 60 YES/NO FAMILY MEMBER:** ……………………………………………

**STROKE** **YES/NO FAMILY MEMBER:** ……………………………………………

**HIGH BLOOD PRESSURE YES/NO FAMILY MEMBER:** ……………………………………………

**DIABETES YES/NO FAMILY MEMBER:** ……………………………………………

**ASTHMA YES/NO FAMILY MEMBER:** ……………………………………………

**COLON CANCER YES/NO FAMILY MEMBER:** ……………………………………………

**PROSTATE CANCER YES/NO FAMILY MEMBER:** ……………………………………………

**BREAST CANCER YES/NO FAMILY MEMBER:** ……………………………………………

**GLAUCOMA YES/NO FAMILY MEMBER:** ……………………………………………

**MEDICAL SUMMARY**

**PLEASE LIST ANY SERIOUS ILLNESSES, HOSPITAL ADMISSIONS OR OPERATIONS THAT YOU HAVE HAD.**

|  |  |
| --- | --- |
| **DATE** | **PROBLEM** |
|  |  |
|  |  |
|  |  |

**WHICH SCHOOL OR NURSERY DOES YOUR CHILD ATTEND?** ………………………………………………………………………………

**DOES YOUR CHILD HAVE CONTACT WITH ANY OF THE FOLLOWING?**

**YES NO**

* **A HOSPITAL SPECIALIST**
* **A HEALTH VISITOR**

**YES NO**

* **A SOCIAL WORKER**

**YES NO**

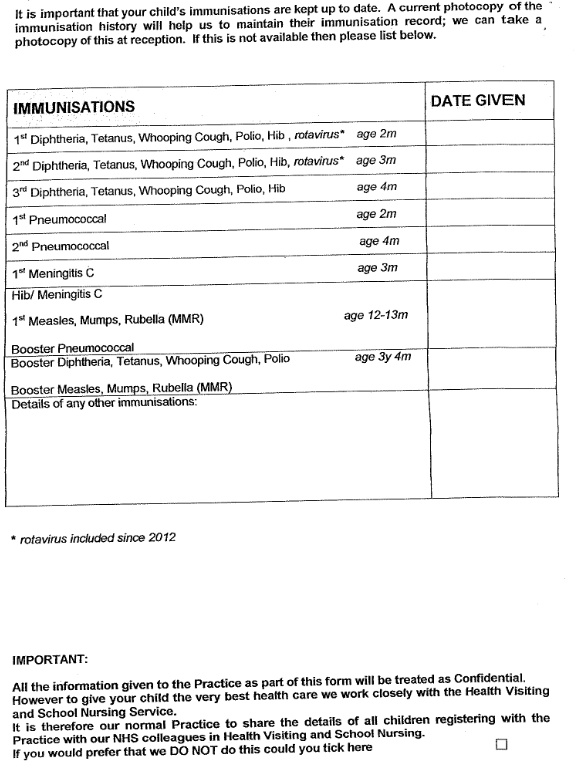
* **ANY OTHER HEALTH PROFESSIONALS?**

**YES NO**

**HAS YOUR CHILD EVER BEEN UNDER A CHILD PROTECTION PLAN? YES NO**

**YES NO**

**YES NO**



**10. ETHNICITY**

**WHAT IS YOUR ETHNIC GROUP?**

**WHITE**

**BRITISH**

**IRISH**

**ANY OTHER WHITE BACKGROUND PLEASE STATE ……………………………………………………………………………**

**MIXED**

**WHITE AND BLACK CARRIBEAN**

**WHITE AND BLACK AFRICAN**

**WHITE AND ASIAN**

**ANY OTHER MIXED BACKGROUND. PLEASE STATE ……………………………………………………………………………**

**ASIAN OR ASIAN BRITISH**

**INDIAN**

**PAKISTANI**

**BANGLADESHI**

**ANY OTHER MIXED BACKGROUND, PLEASE STATE …………………………………………………………………………………………**

**BLACK OR BLACK BRITISH**

**CARRIBEAN**

**AFRICIAN**

**ANY OTHER BLACK BACKGROUND, PLEASE STATE …………………………………………………………………………………………**

**CHINESE OR OTHER ETHNIC GROUP**

**CHINESE**

**ANY OTHER PLEASE STATE ……………………………………………………………………………………………………………………………..**

**NOT STATED**

**FEMALE CHILDREN ONLY**

**FGM – In line with current guidance we now need to ask our female patients the following**

**Are you from a country where FGM (cutting/female circumcision occurs)? Please see list:**

**YES/NO**

**Have you ever been cut?**

**YES/NO**

**If yes are you under 18:**

**YES/NO. If you are under18 we will arrange for a Doctor to discuss the next steps.**

**Do you have female children?**

**YES/NO**

**If yes, is FGM (cutting/female circumcision) something you are considering or have had to your female children?**

**YES/NO**

**If yes we must advise you that is now an illegal practice we would need to report this to the police.**

**Would you like to talk to anyone about FGM?**

**YES/NO**