EASTLEIGH MEDICAL PRACTICE CHILD QUESTIONNAIRE

Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print ☐ Other …….

CONFIDENTIAL MEDICAL REGISTRATION FORM (CHILDREN UNDER 16)

Please complete all pages in FULL using BLOCK capitals Surname

First Names (in full)

Previous Surnames

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐ Female

Date of Birth
(day/month/year)

NHS Number ☐☐☐
☐☐☐ ☐☐☐☐ (if known)

Town & country of Birth

Address

Post Code:

Telephone number: Mobile number:

Email address:

Please help us trace your previous medical records by providing the following information:

Your previous address in UK

Post Code:

Name of previous Doctor while at that address

Address of previous Doctor

Post Code:

If you are from abroad:

Your first UK address where Registered with a GP

Post Code:

If previously resident in UK

date of leaving

Date you first came to UK

If registering a child under 5:

☐ I wish the child above to be registered with Parkside Practice for Child Health Surveillance

If you need your doctor to dispense medicines & appliances*:

For Dispensing Practices only:

☐ I live more than 1 mile in a straight line from the nearest chemist

NHS Organ Donor registration:

I want to register my details on the NHS Organ Donor Register as someone whose organs/tissue may be used for transplantation after my death. Please tick the boxes that apply.

☐ Any of my organs and tissue or

☐ Kidneys ☐ Heart ☐ Liver ☐ Corneas ☐ Lungs ☐ Pancreas ☐ Any part of my body

Signature to confirm agreement to organ/tissue donation is at the bottom of this form. For more *information please ask at reception for an information leaflet or visit the website www.uktransplant.org.uk or call 0300 123 23 23*

NHS Blood Donor registration:

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood. Tick here if you have given blood in the last 3 years ☐

Signature to confirm consent to inclusion on the NHS Blood Donor Register at the bottom of this form.

For more information, please ask for the leaflet on joining the NHS Blood Donor Register. My preferred address for donation is (only if different from above eg your place of work)

…….…… Post code: …….

Personal Medical History…..

Type of Birth:
(eg normal, forceps, Caesarean If under 5)

Birth Weight:
(If under 5)

Feeding:
(Breast or bottlefed If under 5)

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	**Year diagnosed**	**Ongoing**
		Yes/No
		Yes/No
		Yes/No

Family History…..

Have any close relatives (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Immunisations ……

Please provide details of your childs immunisations with dates if possible (under 5's). If possible please give your Red Book to Reception to photocopy:

Immunsation	Date	Immunisation	Date
Tetanus		Booster: Tetanus	
Whooping Cough		Booster: Diphtheria	
Polio		Booster: Polio	
HiB		Booster: MMR	
Measles			
MMR			
BCG (TB)			
Meningitis			

List of current medication ……

Name of medication	Dosage

Allergies ……

Please list any allergies you have to any drugs/medication:

Name of medication	What was the problem or upset?

Ethnicity ……

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian ☐ Pakistani ☐ Bangladeshi ☐ Chinese ☐ Other (please state):

☐ Decline to state

Next of kin ……

Name: Tel. contact number:

Relationship:

Data sharing consent choices ……

To maintain continuity of clinical care, we upload **certain** medical information so that it is available to other healthcare organisations (eg Emergency Departments). Please read the accompanying leaflet which details what part of your record is extracted and how it is used to help other NHS organisations.

If you wish to **OPT OUT** please complete the form found with this leaflet.

Where you have provided information on how to contact you, can you confirm you are happy for Parkside Practice to contact you by the following:

By email ☐ Yes ☐ No This will be to send you letters, newsletter and the like

By text ☐ Yes ☐ No
This will be to send you reminders of appointments via text

Signature ……

I confirm that the information that has been provided is true to the best of my knowledge.

Signed: Date:

Signature on behalf of patient ☐ Signature of patient ☐