**NEW PATIENT HEALTH CHECK FOR UNDER 5 YEARS OLD**

**\*ALL DETAILS WILL BE TREATED IN THE STRICTEST CONFIDENCE\***

**\*\*\*DR RAI IS YOUR NAMED ACCOUNTABLE PRACTITIONER BUT YOU WILL AT TIMES SEE OTHER GP’S\*\*\***

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| First Name: |  | | Surname: | | |  |
| Date of Birth: |  | | | | | |
| Address: |  | | | | | |
|  | | | | | | |
| Home telephone no.: |  | | Mobile telephone no.: | | |  |
| Email Address: |  | | | | | |
|  | | | | | | |
| **We would like to obtain your next of kin details (or other emergency contact) for all patients. Please note we would only contact in the event of an emergency and no confidential information would be revealed in the process.** | | | | | | |
| **Next of Kin** | | | | | | |
| Next of kin’s first name: |  | | Next of kin’s surname: | | |  |
| Relationship to patient: |  | | | | | |
| Address: |  | | | | | |
|  | | | | | | |
| Contact no. 1: |  | | Contact no. 2: | | |  |
| **School/ Nursery Details** | | | | | | |
| Name of School: |  | | | | | |
| Address: |  | | | | | |
| Telephone no.: |  | | | | | |
|  | | | | | | |
| **Equality and Diversity Monitoring: Please help us to ensure that our services are accessible to everyone by filling out the following information.** | | | | | | |
|  | | | | | | |
| **Race (select one section)** | | | | | | |
| 1. **Asian or Asian British** | | | | | | |
| Bangladeshi | | Indian Pakistani | | | Other Asian background | |
| 1. **Black or Black British** | | | | | | |
| African | | Caribbean | | | Other Black background | |
| 1. **Chinese, Polish or any other ethnic group** | | | | | | |
| Please specify: | |  | | | | |
| 1. **Mixed Heritage** | | | | | | |
| White + Asian | White + Black African | | White + Black Caribbean | | | Other mixed heritage background |
| 1. **White** | | | | | | |
| British | English | | | Irish | | Scottish |
| Welsh | Other white background | | | Prefer not to say | |  |
| **Family History** | | | | | | |
| Please indicate if you have a family history of: | | | Please indicate which family member was affected: | | | |
| Heart Disease : | | |  | | | |
| High B.P. : | | |  | | | |
| Diabetes : | | |  | | | |
| Stroke : | | |  | | | |
| Other  (please specify): | | |  | | | |

|  |  |
| --- | --- |
| **Allergies** | |
| **Please state if you have any allergies:** |  |
|  | |
| **Past Medical History** | |
| **Please indicate any significant past medical history:** |  |

**Would you like to sign up your child up for our FREE ONLINE services? Yes**  **No**

**With PATIENT ACCESS you can:**

**1) View information such as your medications and allergies, etc.**

**2) Get a free Patient Access application for your phone/ tablet.**

**3) Use our online appointment service and prescription request services.**

**To join up tick the YES option above and we will contact you once we have signed you up.**

**For details of this you can ask at reception when you register, or you can visit patient.co.uk/access**

**Many thanks for taking the time to complete this questionnaire.**