GRANGE MEDICAL PRACTICE

UNDER 16s PATIENT QUESTIONNAIRE

Welcome to the Grange Medical Practice. Please complete this questionnaire or complete on behalf of your child All the information you provide is strictly confidential and will become a part of your medical record	
Title Miss /Master	
Surname:	
First Name	
Date of Birth	Male/ Female
Address:	
Postcode:	
Emergency Contact Number	
Name of Parent or guardian	
Tel of parent or guardian if different from above	

Ethnicity

African		Other black background	
Bangladeshi		Other mixed background	
British or Mixed British		Other white background	
Caribbean		Pakistani or British Pakistani	
Chinese		Mixed white and Asian	
Irish		Mixed white and black African	
Indian or British Indian		Mixed white and Caribbean	
Other Asian Background		Other	
European		I do not want to give my ethnic origin	

Do you have a disability we should be aware of?

Do you have any allergies?

Smoking (14 years and over)

Do you smoke Yes/No	
If yes how many?	
Would you like advice to give up?	

Do you take the contraceptive pill?	
Do you use another form of contraception	
Would you like advice regarding contraception?	

Have you had any serious illnesses or operations?

Serious illnesses	
Operations	

Are your childhood immunisations up to date? Yes/No If no please give further information

<u>All children under five must provide evidence of childhood immunisations</u>

FOR OFFICE USE ONLY

Address Verified: YES / NO

_____

Staff Member:

Date: _____