



# NEW PATIENT QUESTIONNAIRE 0 -10 Yrs

Please fill out all pages

Title: \_\_\_\_\_ Surname: \_\_\_\_\_

Forename(s) \_\_\_\_\_

Sex: Male Female (circle)

D.O.B \_\_\_\_\_

Mother's Name: \_\_\_\_\_

Father's Name: \_\_\_\_\_

Do they have parental responsibility

Do they have parental responsibility

Mother's Tel: \_\_\_\_\_

Fathers' Tel: \_\_\_\_\_

Home Tel: \_\_\_\_\_

Address of parent with responsibility who may not be living with child: \_\_\_\_\_

Next Of Kin: Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contact No: \_\_\_\_\_

**PLEASE NOTE:** In order to maintain the confidentiality of this patient's medical record, parent's/ guardian's mobile number(s) will be removed from their record when the patient reaches 11 Years old.

## Patient Ethnic Origin Questionnaire

This questionnaire follows the recommendations of the *Commission for Racial Equality* and complies with the Race Relations Act. Please indicate your child's ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Please record the MAIN SPOKEN language your child uses: \_\_\_\_\_

They require a language interpreter

They require a BSL interpreter

<b>A) WHITE</b>	British	Irish	Any other white back ground: #9i2	
<b>B) MIXED</b>	White & Black Caribbean #9i3	White and Black African #9i4	White and Asian #9i5	Any other mixed background #9i6
<b>C) ASIAN OR ASIAN BRITISH</b>	Indian	Pakistani	Bangladeshi	Any other Asian background #9iA
<b>D) BLACK OR BLACK BRITISH</b>	Caribbean #9iB	African #9iC	Any other black background:9iD	
<b>E) CHINESE OR OTHER ETHNIC GROUP</b>	Chinese	Any other ethnic group #9iF		
<b>F) DECLINED</b>	#9SD			

Choose ONE section from A to F and circle ONE box to indicate your background

**Measurements**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**MEDICAL HISTORY:** *Please list all significant medical problems where possible, e.g.*

*Major Operations, Diabetes, Asthma, Heart Disease, Strokes*

**FAMILY HISTORY** *Have any of your Parents, Brothers or Sisters suffered from Heart Disease, Diabetes, Asthma, High Blood Pressure or Strokes? If yes, please give their ages, relationship to you and age at diagnosis:*

**MEDICATION :** *Please list all medication you are currently taking*

**ARE YOU ALLERGIC TO ANY DRUGS:**

**Vaccinations :**

Is your child up to date with their vaccinations? Y/N (Circle)

**Administration:**

My child is an immediate family member of a Military Veteran? **Y/N** (Circle)

My child already uses EPS and want to continue to use the following pharmacy: \_\_\_\_\_

I Consent to my child using the Electronic Prescription Service: **Y/N** (Circle)

Please send my child’s prescriptions to the following pharmacy: \_\_\_\_\_

Parent’s Name: \_\_\_\_\_

Parent’s Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Office use only	
Staff Initials	
Date handed in	
Co. signed by	
Date entered on EMIS	

# Opt In/Out Patient Choice Form

For more information on data sharing please see our web site under GDPR and also [www.nhsdatasharing.info](http://www.nhsdatasharing.info).

Please tick the following if you wish to **OPT-IN**

*Please note that by opting out of the SMS Texting ,EMAIL or Telephone notifications, you will not receive appointment reminders or health information*

To receive SMS text reminders for appointments and health promotion information	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
To receive Email reminders for appointments and health promotion information	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>
To receive telephone reminders for appointments and health promotion information	YES	<input type="checkbox"/>	NO	<input type="checkbox"/>

## \*IMPORTANT INFORMATION ABOUT YOUR HEALTH RECORD (Please read carefully)

The NHS shares data from your medical record in a number of ways. You have the right to control how your personal information is used and who has access to it. You can opt out of this data sharing by completing the form below. We will then add relevant coding to your record to stop the extraction and processing.

**I agree to the following information to be extracted and uploaded from my GP record for the following purposes:**

### **National Data Opt-Out**

This information is used by NHS England and Public Health England to determine future demand on services, or for research into the treatment of conditions. This will also include the National Diabetic Audit and other National Audits that the practice may part in. (<https://digital.nhs.uk/data-and-information/clinical-audits-and-registries/national-diabetes-audit>)

To **Opt Out** of this please visit <https://www.nhs.uk/your-nhs-data-matters/> where you will need to register your preference not to take part. **We cannot do this for you.**

**The following options are for data sharing related to your direct health care. It is important you let us know your choices. You have the right to change your mind at any time.**

**The Summary Care Record**— Please opt me out of the Summary Care Record YES  NO   
*(If you select YES please **do not** tick the any of the two options below)*

I Express consent for medication, allergies and adverse reactions only. YES

I Express consent for medication, allergies, adverse reactions and additional information. YES

The Summary Care record is a national record which can be accessed by healthcare professionals who may need to treat you in other parts of the country. It contains information on your main diseases, medications ,allergies, immunisations, care plans and significant medical history (past and present) which may be crucial to your care in an emergency situation. If you do not want your data to be available to other services on the national spine, please let the practice know and we will ensure you are **Opted out** of this data sharing

YES  NO

**The Care and Health Information Exchange, (CHIE)** - Please Opt me out of the Hampshire CHIE

CHIE is a Hampshire wide database which healthcare professionals in other practices and the local hospitals can access if they need to treat you. They can ask you to view your practice record, such as when you visit a local Hub – and this may be important to providing you with the correct care. It is not available to health services outside of Hampshire – who would use the Summary Care Record to obtain important information about you.

**I understand that I can opt my child in/out to any or all of these databases at any time in the future by informing the Practice in writing.**

Patient Name: \_\_\_\_\_ Parent Name: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_