CHEVIOT ROAD SURGERY NEW PATIENT HEALTH QUESTIONNAIRE	AGES 0 -12 YEARS

NAME OF PATIENT: ……..

HOME ADDRESS: …….

DOB: ……..ETHNIC GROUP: …….....

LANGUAGE: …… INTERPRETER REQUIRED: …….

MOTHER'S NAME: …….

FATHER'S NAME: ……..

PARENT'S CURRENT PARTNER'S NAME……

IF YES, NAME OF PARENT /GUARDIAN? ……..

NAME OF SCHOOL …….

DOES THIS CHILD HAVE A SOCIAL WORKER? YES ☐ NO ☐

NAME OF PERSON WITH PARENTAL RESPONSIBILITY : ……

CONTACT NUMBER/S: ……
Do you wish to be contacted by text message? YES ☐ NO ☐

EMAIL ADDRESS: ……

Has this child ever had any of the following?

	NO	YES
Heart Problems		
Diabetes		
Asthma Chronic Bronchtitis or Emphysema		
Epilepsy, fits or seizures		
Thyroid problems		
Cancer of any type		
Learning Disabilities		
Significant Mental Health problems or severe depression		
Any other serious illnesses that you feel may be relevant? Please list below		
Please list any serious allergies below:		