CHEVIOT ROAD SURGERY NEW PATIENT HEALTH QUESTIONNAIRE	AGES 13 -15 YEARS

NAME OF PATIENT: ……..

HOME ADDRESS: …….

DOB: ……..

YOUR CONTACT NUMBER/S (NOT PARENTS NUMBER): ……..
Do you wish to be contacted by text message? YES ☐ NO ☐

YOUR EMAIL ADDRESS: ……

ETHNIC GROUP: …….....

LANGUAGE: …… **INTERPRETER REQUIRED: …….**

NAME OF SCHOOL …….

DO YOU HAVE A SOCIAL WORKER? YES ☐ NO ☐

Have youever 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:		

Which of the following best describes you?

☐I have never smoked

☐I have smoked in the past but do not smoke now

☐I am a current smoker. Please list how many cigarettes/cigars etc you smoke per day

SMOKING TOBACCO IS HARMFUL. If you are a smoker and would like to quit, please speak to your Doctor or Practice Nurse.

MOTHER'S NAME: …….

FATHER'S NAME: ……..

NAME OF PERSON WITH PARENTAL RESPONSIBILITY : ……

UPDATED 27.06.18