GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

NEYLAND & JOHNSTON MEDICAL PRACTICE

NEW ADULT PATIENT REGISTRATION HEALTH QUESTIONNAIRE

For information on how we will use your data please click on this link Full privacy notice - Hywel Dda University Health Board or go to https://hduhb.nhs.wales/about-us/governance-arrangements/your-information-your-rights/privacy-notices/full-privacy-notice/

NEW PATIENT REGISTRATION HEALTH QUESTIONNAIRE - CHILD UNDER 15

As your child is a new patient to the Practice it would be helpful if you could give us the following information. **Please bring the child's RED BOOK when you register your child**. All information on this form will be kept confidential. Please return the completed forms to reception along with the registration form.

Personal details:

Preferred Pronouns: e.g.: he/him, she/her, they/them		Title (Mr/Mrs/Miss etc.)	
Surname:	First Name(s):		
NHS number:	D.O.B.		
Marital Status:			
Address:			
	Postcode:		
Home Tel Number:	Mobile Tel Number:		
Email Address:			
Family Details:			
Mother's Name:	Father's Name:		
Contact Tel No.:	Contact Tel No.:		
Address (if different from child):	Address (if different from child):		
Postcode:	Postcode:		
Who has parental responsibility? (Please tick one or both if applicable. Please provide a copy of the child's birth certificate for confirmation of parental responsibility) Mother ☐ Father ☐ Someone Else ☐ (please state name and relationship to below)			
Emergency contact details: these contacts will only be used in case of an emergency			
Name of next of kin:	Name of Other Emergency Contact:		
Contact Tel No.	Contact Tel No.		
Relationship to patient:	Relationship to patient:		

Do you consent to the practice contacting you by text message for appointment reminders, invitations to health checks, vaccination reminders, and anything else relevant to your healthcare? YES ☐ NO ☐

We have an electronic method of contact available for patients to contact the surgery for non-urgent requests – do you consent for us to correspond with you via this method and supply us with a preferred e-mail address for this purpose? YES ☐ NO ☐

ETHNIC ORIGIN: I would describe my ethnic origin as (please tick)

WHITE		**ASIAN, ASIAN WELSH OR ASIAN BRITISH**		**Black, Black Welsh, Black British, Caribbean or African**		**Mixed or Multiple Ethnic or Other Ethnic Group**	
Welsh		Indian		Caribbean		White & Black Caribbean	
English		Pakistani		African		White & Black African	
Scottish		Bangladeshi		Any other Black, Black British or Caribbean background		White & Asian	
Northern Irish		Chinese				Any other mixed or multiple ethnic background	
British		Any other Asian Background-					
						Arab	
						Any other ethnic group	

LANGUAGE PREFERENCE (Please select one) WELSH ☐ ENGLISH ☐ OTHER ☐
If other, please specify:

IS YOUR GENDER INDENTITY THE SAME AS THE SEX YOU WERE REGISTERED AT BIRTH?
Yes ☐ No ☐ Prefer Not to Say ☐

WHICH GENDER DO YOU INDENTIFY WITH? (Please tick): Male ☐ Female ☐
Other Preferred Description ☐ Prefer Not to Say ☐

Please list all members of your household (children & adults) that share the house with the child and their relationship to the child.

Name of person	Adult or Child (under 18)	Relationship to patient	Registered at this practice
		Mother	YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐
			YES ☐ NO ☐

Relevant Medical History – Is your child on any medication at present? YES ☐ NO ☐

If yes, please provide a list below:

Allergies: *Have you ever experienced an adverse reaction? If yes, please specify medication and/or environmental (including food stuff etc.), and what reaction you experienced e.g. sickness, rash, anaphylaxis*. No ☐ Yes ☐

If yes, please state the following:

What was the allergy to?	What was the reaction?

Has your child had any operations or a serious illness? YES ☐ NO ☐

If yes, please provide information

Please detail any special needs your child may have so the Practice can ensure they are identified and can be accommodated by taking the appropriate measures. Does your child have any of the following disabilities?

Physical/Mobility (please specify) ☐ Visual ☐ Hearing ☐

Other – please specify below ☐

Does you child have any mental disabilities / special educational needs? YES ☐ NO ☐

If yes, please specify.

LIFESTYLE

DIET – do you follow a special diet? Yes ☐ No ☐ If yes, please specify:

Does anyone Smoke and / or Vape in the household? YES ☐ NO ☐

If yes, please provide details:

OTHER INFORMATION:

Is your child home schooled? YES ☐ NO ☐

If no, please provide Name of current school –

Name of previous school (if applicable)

Name of Health Visitor / School Nurse (if known) -	
Has your child ever been allocated a social worker or FNP? If yes, when	YES ☐ NO ☐
Has your child ever been the subject of a Child Protection Plan? If yes, when	YES ☐ NO ☐
Has your child ever been a 'looked after' child (i.e. foster care or in a children's home)?	YES ☐ NO ☐
CARERS	
Does your child have a carer?	YES ☐ NO ☐
Is your child a carer?	YES ☐ NO ☐
If yes, please ask a member of staff about carers support who can provide a carers support form Once you have completed a form, a carer's pack will be sent to you which contains further information about the help and services available to carers. All Carers are entitled to a CARERS ASSESSMENT. This can provide you with a link to help and support.	
FAMILY HISTORY – *Is there any of the following in your family (father, mother, brother, sister, grandparents) before the age of 65? Please specify the family member.*	
Heart Disease	No ☐ Yes ☐
Stroke	No ☐ Yes ☐
Cancer	No ☐ Yes ☐ State what type of cancer:
Diabetes	No ☐ Yes ☐ Type 1 ☐ Type 2 ☐ If known.

TRANSFER IN/CHANGE OF DETAILS OF CHILDREN 0-5 YEARS OLD

Dear Parents, this information is required by the health visitors in the surgery. This will enable the Health Visitors to contact you and to update the children's records in child health, who are responsible for the Immunisation and child health surveillance program.

A. Moved into Neyland Area YES ☐ NO ☐
B. Moved within Neyland Area YES ☐ NO ☐
C. Changed telephone number YES ☐ NO ☐