|  |  |
| --- | --- |
|  | Valkyrie Surgery New Patient Health Questionnaire for under 16 years |

## Childs Contact Details

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title |  | First names |  | Surname |  |
| Date of birth | | |  |  |  |  |
| Home Address  (Including flat number) | | |  | | |
| **Parent or Guardian detail** | | | | | |
| First Name | | |  | Surname |  |
| Relationship to child | | |  | Mobile |  |
| Address | | |  | | |
| Mother name if different from above | | |  | mobile |  |
| Fathers name if different from above | | |  | Mobile |  |
| Address if different from above | | |  | | |

|  |  |
| --- | --- |
| Previous GP |  |
| Previous GP address |  |

**MEDICAL INFORMATION**

|  |  |
| --- | --- |
| Please list any serious illnesses/operations/ accidents/disabilities, | |
| Year | Description |
|  |  |
|  |  |
|  |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please list your current medication | | | | | | | | |
| Drug/inhaler name | | Strength mg/mcg | | | | | How many times per day | |
|  | |  | | | | |  | |
|  | |  | | | | |  | |
|  | |  | | | | |  | |
|  | |  | | | | |  | |
| **Please note before registering at Valkyrie Surgery make sure you have obtained enough medication from your old practice to cover you for at least 1 month** | | | | | | | | |
| **All prescription will be sent electronically** | | | | | | | | |
| Who is your nominated pharmacy ? | | | | |  | | | |
| Are you allergic to any medications? | | | | | | | | |
| Medication | | | Allergy | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
|  | | |  | | | | | |
| Family history | | | | | | | | |
| Please sate any serious illness, in particular cancer, heart disease, stroke, high blood pressure, diabetes, or any inherited disease | | | | | | | | |
| Disease | | | | | | | | Relationship to you |
|  | | | | | | | |  |
|  | | | | | | | |  |
|  | | | | | | | |  |
| Families Additional support | | | | | | | | |
| Does you child have a social worker? | | | | | | | |  |
| Is the child in a care home or fostered? | | | | | | | |  |
| Who has parental responsibility? | | | | | | | |  |
| Next of Kin | | | | | | | | |
| Name |  | | | Address | |  | | |
| Telephone number |  | | | Relationship to you | |  | | |
| Signatures | | | | | | | | |
| Signature |  | | | Date | |  | | |