|  |  |
| --- | --- |
|  | 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  |  |