New Patient Questionnaire: Children or Young People aged below 18 (To be completed with GMS1)

PERSONAL DETAILS		
Name: **Alternative name(s):**		**NHS Number:** **DOB:**
School:		
Religion (*Please circle)*	Christian Buddhist Hindu Jewish Muslim Sikh Any other religion, please describe:	
Do you or the child consider them to have a disability? *(Please Circle)*	No Yes: Physical Sensory Learning Disability Mental Health Other:	
Ethnicity (*Please circle)*	**White** British Irish Gypsy or Irish Traveller Any other White background, please describe:	**Mixed/Multiple ethnic groups** White and Black Caribbean White and Black African White and Asian Any other Mixed/Multiple ethnic background, please describe:
	Asian/Asian British Indian Pakistani Bangladeshi Chinese Any other Asian background, please describe:	**Black/ African/Caribbean/Black British** African Caribbean Any other Black/African/Caribbean background, please describe:
		Other ethnic group Arab Any other ethnic group, please describe:
First language:		**Immigration status:**

COMMUNICATION REQUIREMENTS		
Does the child require any of the following: *(Please circle all that apply)*	I need an Interpreter I use lip reading I use textphone / Minicom	I need large print I rely on British Sign Language

PARENT / CARER (S) DETAILS	
Person (s) with Parental Responsibility:	
Name: **DOB:** **Address** *if different to child:* **Contact No:** **Relationship to child:**	**Name:** **DOB:** **Address** *if different to child:* **Contact No:** **Relationship to child:**

Main carer details *(if different to person with parental responsibility)*	**Name:** **DOB:** **Address** *if different to child:* **Contact No:** **Relationship to child:**
Is the child subject to any legal orders? (*Please circle)*	Yes No

MEDICAL HISTORY

Child Health and Development: *(Please circle)* Hearing problems Vision Problem Seizures in Childhood Literacy Problems Allergies Allergies to Medication Hip Problems Heart Conditions Asthma Diabetes Contact with Tuberculosis Infectious Diseases Cancer Mental Health Other (Please specify)	**Any further comments:**
Family medical history: *(Please circle and specify who in further comments)* Hearing problems Vision Problem Seizures in Childhood Literacy Problems Allergies Allergies to Medication Hip Problems Heart Conditions Asthma Diabetes Contact with Tuberculosis Infectious Diseases Cancer Mental Health Other (Please specify)	**Any further comments:**

Height:		**Weight:**		**BMI:**	
Diet / Nutrition:			**Dental Care / Registered Dentist:**		

CURRENT MEDICATION *(Please list)*	
Health Condition	**Medication Required**

IMMUNISATION HISTORY	
Immunisation	**Date Given**
BCG	
1st Diptheria/ Tetanus/ Pertussis/ Polio/ Hib 1st Pneumococcal 1st Rotavirus	
2nd Diptheria/Tetanus/Pertussis/Hib 1st Meningitis C 2nd Rotavirus	
3rd Diptheria/Tetanus/Pertussis/Hib 2nd Pnemococcal	
Hib/Meningitis C MMR 1 Pneumococcal booster	
Diptheria/Tetanus/Polio/Pertussis booster	
MMR 2	
HPV (Girls only)	
Diptheria/Tetanus/Polio booster Meningitis C booster	
Other	

To be completed at New Patient Medical

Other service involvement

Service	Practitioner Name	Contact Details

Health and Development of Child: Development, emotional/ behavioural presentation, alcohol intake, substance misuse, contraception,
Health Issues identified on questionnaire **Do you drink alcohol** **Do you take any drugs** **Discuss contraception (Consider Child Sexual Exploitation)** **Any concerns with presentation of child eg emotional/ behavioural** **For children under 1 year discuss safe sleep**

Family and environmental factors

Home Environment: Is anything regarding living environment likely to impact on child i.e Private/ Council, Secure tenancy/ mortgage, homeless, others in household, is house overcrowded, recent bereavement, criminality, financial issues
Is the child living with someone who is not a parent or a close family relative **Discuss fire safety**

FGM Routine Questioning

(1) Do you or your family come from a community where cutting or circumcision is practised? (Please remember you might need to consider that this relates to the patient's parent's country of origin).

(2) Have you been cut? (It may be appropriate to use other terms or phrases)

If you answer YES to questions (1) or (2) please complete FGM risk assessment

Consider selective questioning regarding Domestic Abuse if there are indicators this may be an issue (only question if young person is alone)

Prompt questions that may help facilitate routine enquiry for domestic abuse:

1) Do you currently or have you ever felt frightened of someone that you live with?
2) Has your partner ever hit you?
3) Have you ever been emotionally or physically hurt by someone close to you?
4) Have you ever been forced to do anything sexually that you did not want to do?
5) Since you became pregnant have you ever been physically hurt by someone? (DOH, 2006)

Response to Routine Enquiry

- No experience of domestic abuse
- Declined to answer
- Yes, in the past, not with current partner
- Yes, current experience disclosed
- Unable to ask as partner or other present

Additional Comments:

Consider Is the child aged 16-17 years

- Children who are 16-17 years ideally should be registered with an adult who has parental responsibility. However if this is not the case information should be sought on

    - Their residence. If homeless consider referral to Children's Services for joint housing and social work assessment
    - Who they are residing with and they should be linked on the GP system if registered at the same practice or details of their GP should be recorded to allow liaison if there are safeguarding concerns. Consider does anyone they are residing with pose a risk of significant harm
    - Any other agencies working with the child. Liaison should take place with these agencies to ensure they are aware the child is registered at the practice without an adult and potential vulnerabilities

Signed:	
Date:	