Cathays Surgery - New Patient Health Forms (CHILD - Under 16)

Please complete as accurately as you can and return to the practice

Identification & Contact Details

Forename (s):		Date of birth:	(dd/mm/yyyy)
Surname:		Gender:	

Town/Country of birth:		**Will you require a translator support?**	**Yes / No** (We can only provide translation support **DURING** appointments)
Main lanugage spoken:			

Home phone number:		Mobile phone number:	
Email address:		Preferred method of contact:	Phone / SMS / Email
Who's contact details are provided above:	Child's / Parent's or Guardian's		

Are you happy for us to send you health-related marketing text messages or emails? We may occasionally wish to send you invitations to clinics and other health care services that we feel would be beneficial to your child's health, such as flu vaccines. This is now being classed as marketing. **Be assured, we will NEVER share you or your child's details to a non-NHS third-party organisation for marketing purposes.**	Yes / No

Family Details

This will help us link your family together if you are also registered at this practice.

Parent / Guardian name:		Please tick this box if you DO NOT want this person to be linked to the child on our systems - ☐	
Date of Birth:		**Contact phone number:**	

Parent / Guardian name:		Please tick this box if you DO NOT want this person to be linked to the child on our systems - ☐	
Date of Birth:		Contact phone number:	

Sibling(s) names:	

Lifestyle Questions

Who does your child live with?			
What school does your child attend?		Is this a special needs school?	
Is your child an asylum seeker/ refugee?	**Yes / No**	Has your child ever been on the 'At Risk' register?	
Is your child a young carer?	Yes / No	If yes, who do they care for?	

Medical History

Does your child have any allergies that you are aware of?	**Yes / No** - **If yes, please give details below.**		
	Allergy to e.g. foods, medicines, animals etc.	**Type of reaction** e.g. rash, swelling etc.	**Severity**

Has your child EVER suffered from the following? - if yes, please tick the appropriate box and add the date they suffered from the condition.

☐ - Epilepsy	☐ - Diabetes	☐ - Cancer	☐ - Asthma
☐ - Hayfever	☐ - Jaundice	☐ - Skin Disease	☐ - Heart conditions

Please give details of any other significant illnesses your child has had:

Do you have a family history of any illnesses? If yes, please give details.	

Turn the page to continue...

Medical History continued...

Does your child take any routine medication? (e.g. inhalers)	Drug name	Dose	How many times a day?

Does your child have any disabilities? - if yes, please tick the appropriate box and add the date the condition started.			
☐ - Impaired Hearing/Deaf	☐ - Speech Impaired	☐ - Partially Sighted/Blind	☐ - Mobility Impaired
☐ - Learning Disabilities	☐ - Other, please give details here:		

Does your child require any specific support?	Yes / No	If yes, please give details of what support they require:	

Has your child ever attended A&E?	Yes / No	If yes, why and when?	

Immunisations

Has your child had any of the following immunisations/vaccines?			
☐ - DTaP/IPV/Hib (1)	Date:	☐ - Pneumococcal (1)	Date:
☐ - DTaP/IPV/Hib (2)	Date:	☐ - Pneumococcal (2)	Date:
☐ - DTaP/IPV/Hib (3)	Date:	☐ - Pneumococcal (1)	Date:
☐ - Hib/MenC	Date:	☐ - MMR (1st) (Measles, Mumps, Rubella)	Date:
☐ - MenC (1st) (Meningitis)	Date:	☐ - MMR (Booster) (Measles, Mumps, Rubella)	Date:
☐ - MenC (2nd) (Meningitis)	Date:	☐ - DT Booster	Date:
☐ - Covid-19 (1)	Date:	☐ - Polio Booster	Date:
☐ - Covid-19 (2)	Date:	☐ - Human Pappillomavirus (HPV)	Date:

Thank you for completing this form!