GRANGE MEDICAL GROUP

NEW PATIENT QUESTIONNAIRE

TO BE COMPLETED FOR ALL PATIENTS UNDER 16 YEARS

FIRST NAME…… SURNAME ……..….

PREVIOUS SURNAME……..…….……..

ADDRESS ……..……..
Home:

DATE OF BIRTH ……. TELEPHONE No: Mobile:…….

PLACE OF BIRTH ……... NATIONALITY…….……
Home:

NEXT OF KIN ……TELEPHONE No: Mobile:…….……...…...

RELATIONSHIP TO PATIENT: ……..…..…..

HAVE YOU BEEN REGISTERED WITH THE GRANGE MEDICAL GROUP PREVIOUSLY?
YES/NO

REGISTERING FOR THE FIRST TIME IN THE UK

DATE OF ENTRY INTO UK …… LENGTH OF STAY IN UK…….

REASON FOR STAY…….……

Have you had any illnesses or operations? YES/NO
Please list below:-

Date (Approx.)	Illness/Operation

Do you take any regular medication? YES/NO
Please list below**:**

Drug	Dose	How Many Times A Day

Carer

If you have any complex health needs:
Do you have a carer? YES / NO
If yes, who is your carer?

Name……. Relationship…….. Telephone…….

Are you a carer? YES / NO
If yes, who do you care for?

Name……...Relationship……Telephone……

Are you allergic to any medications? YES/NO
If so, what? ……

Do you smoke? (Those aged 15 years and over) YES/NO
If so, how much do you smoke? ……..……...
Have you ever smoked? YES/NO

Family History

Do any of your family or close relatives have any of the following conditions?

Condition	YES/NO	Please Give Details
Diabetes		
Heart Disease		
Stroke		
Asthma		
High Blood Pressure		
Cancer (**please specify)**		
Glaucoma		
Epilepsy		

Patient Statement:

This questionnaire has been completed to the best of my knowledge

Completed by, signature……

If the above is not the patient please specify relationship……..

Date questionnaire completed……

GRANGE MEDICAL GROUP

Name _____

Date of Birth _____

CHILDHOOD IMMUNISATION HISTORY

Immunisation	**Date**
1st Diphtheria, Tetanus, Whooping Cough, Polio, Hib	
2nd Diphtheria, Tetanus, Whooping Cough, Polio, Hib	
3rd Diphtheria, Tetanus, Whooping Cough, Polio, Hib	
1st Pneumococcal	
2nd Pneumococcal	
1st Meningitis C	
1st Rotavirus	
2nd Rotavirus	
1st Meningitis B	
2nd Meningitis B	
3rd Meningitis B	
Hib/Meningitis C	
1st Measles, Mumps, Rubella [MMR]	
Booster Pneumococcal	
Booster Diphtheria, Tetanus, Whooping Cough, Polio	
Booster Measles, Mumps, Rubella [MMR]	
Tuberculosis (BCG)	
Others – Please specify	

Name: _____ Date of Birth _____

What is your ethnic group? Chose ONE section from A to E then tick the appropriate box to indicate your ethnic group.

A: White

- ☐ British
- ☐ Irish
- ☐ Any other White background, please state _____

B: Mixed

- ☐ White and Black Caribbean
- ☐ White and Black African
- ☐ White and Asian
- ☐ Any other mixed background, please state _____

C: Asian or Asian British

- ☐ Indian
- ☐ Pakistani
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Any other Asian background, please state _____

D: Black or Black British

- ☐ Caribbean
- ☐ African
- ☐ Any other Black background, please state _____

E: Any Other Background

- ☐ Please state _____

☐ **Do Not Wish to Answer**

DO YOU REQUIRE AN INTERPRETER? YES/NO

If YES, what language?_____

GRANGE MEDICAL GROUP
Patient Text Messaging Service

In line with **General Data Protection Regulation (GDPR)** we are currently updating our Data Protection Notice. As part of this process in order to continue communicating with you by text message (for appointment reminders and disease recall etc) we are required to **obtain your consent** and to **ensure our records are kept up to date.**

We would be grateful if you would take a moment to complete this slip.
Please note that the age of consent (for processing personal data) for a child with capacity is 12 years old.

I consent to text messaging for appointment reminders/ recalls: YES NO
(Please circle)

I am aware that I may withdraw consent at any time: YES

NAME	
DATE OF BIRTH	
MOBILE TELEPHONE NUMBER	