

# New Child Patient (Age 7 - 16) evolution health **NHS**

Please complete the following information on behalf of your child and hand your form in to a member of reception staff. **All information is kept strictly confidential.**

## Patient Details

Male  Female

Surname

Forename

DOB

NHS Number

## Parent / Guardian Details

Name

Relationship to Child

Email

Address

Postcode

Phone

Contact me via email/text

## Ethnicity

- White  
 White British  
 White Irish  
 White Other

- Black  
 Caribbean  
 African  
 Black Other

- Other Ethnic Groups  
 Chinese  
 Any other Ethnic Group

I do not wish to state my ethnicity

- Mixed  
 White and Black Caribbean  
 White and Black African  
 White and Asian  
 Mixed Other

- Asian or Asian British  
 Indian  
 Pakistani  
 Bangladeshi  
 Asian Other

## First Language (Children and babies ethnicity and first language will be defined as Parent/Guardian)

- Arabic  
 British Signing Language  
 English  
 French  
 Hindi

- Urdu  
 Bengali  
 Tigrinya  
 Spanish  
 Chinese (Cantonese/Mandarin)

Other (please specify below)

## Child Protection

Which school does your child attend?

Has your child ever been on the child protection register?

## Smoking

Does anyone in your household smoke? Yes  No

Smoking in the presence of children is a health risk. If you or anyone in your household would like help and advice to give up smoking, please tick the box.

### Urine Analysis (HCA to complete)

Protein

Glucose

Blood

### Medication

Is your child on any medication? If so, please specify below.

Name of Medication e.g. Metformin

Dose e.g. 500mg

How many per day e.g. 3 tablets p/day

### Allergies

Does your child have any allergies to the following? If so, please tick where appropriate.

Pollen (Hay Fever)

Medicine e.g. Penicillin

Cosmetics

Nuts

Other

Dairy

If you ticked any of the boxes above, please give detail below.

### Operations

Has your child had any operations?

Name of Operation

Name of Hospital

Approximate Date

### Family History

Is there any family history of the following medical conditions? If so, please tick below.

Asthma  Diabetes  Hypertension  Heart Disease  CVA / Stroke  Epilepsy  Cancer

If you ticked any of the boxes above, please give detail below.

**Immunisations** Please tick where appropriate

Other, please state

School Boosters (Around 13 Years)

Diphtheria, Tetanus & Polio

MMR

BCG

HPV (cervical cancer)

I

Mother / Father of

confirm that all information given is correct and completed to the best of my ability.

DD / MM / YY

PLEASE SIGN IN THE BOX