

0-5 YEARS QUESTIONNAIRE

NAME	
DATE OF BIRTH	
NAMES OF PEOPLE WITH PARENTAL RESPONSIBILTY	
What is your main language spoken at home?	
Has your child had any illnesses/operations?	
Is your child on any medicine/creams/inhalers?	
Has your child had any severe reaction to any previous vaccines? (if so which and When)	
Any other relevant medical history	

Do you think your child is up-to-date with their immunisations? YES NO

If not, please leave a message at reception for the Health Visitor or Practice Nurse to discuss.

Ethnic Group	<p>I would/would not like my ethnic group to be recorded in my records (delete as appropriate)</p> <p>Please record it as:</p>
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Patient's details

Please complete in **BLOCK CAPITALS** and tick as appropriate

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Surname
Date of birth	First names
NHS No.	Previous surname/s
<input type="checkbox"/> Male <input type="checkbox"/> Female	Town and country of birth
Home address	
Postcode	Telephone number

Please help us trace your previous medical records by providing the following information

Your previous address in UK	Name of previous doctor while at that address
	Address of previous doctor

If you are from abroad

Your first UK address where registered with a GP

If previously resident in UK, date of leaving	Date you first came to live in UK
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If you are returning from the Armed Forces

Address before enlisting

Service or Personnel number	Enlistment date
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If you are registering a child under 5

I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance

If you need your doctor to dispense medicines and appliances*

**Not all doctors are authorised to dispense medicines*

- I live more than 1 mile in a straight line from the nearest chemist
- I would have serious difficulty in getting them from a chemist

Signature of Patient
 Signature on behalf of patient
 Date

NHS Organ Donor registration

I would like to join the NHS Organ Donor Register as someone whose organs may be used for transplantation after my death. Please tick as appropriate

- Kidneys
 Heart
 Liver
 Corneas
 Lungs
 Pancreas
 Any part of my body

Signature confirming consent to organ donation

Date

For more information, please ask for the leaflet on joining the NHS Organ Donor Register

NHS Blood Donor registration

I would like to join the NHS Blood Donor Register as someone who may be contacted and would be prepared to donate blood.

Tick here if you have given blood in the last 3 years

Signature confirming consent to inclusion on the NHS Blood Donor Register

Date

For more information, please ask for the leaflet on joining the NHS Blood Donor Register

My preferred address for donation is: (only if different from above, e.g. your place of work)

Postcode:

To be completed by the doctor

Doctors Name

HA Code

- I have accepted this patient for general medical services
 For the provision of contraceptive services
 I have accepted this patient for general medical services on behalf of the doctor named below who is a member of this practice

Doctors Name, if different from above

HA Code

- I am on the HA CHSlist and will provide Child Health Surveillance to this patient **or**
 I have accepted this patient on behalf of the doctor named below, who is a member of this practice and is on the HA CHS list and will provide Child Health Surveillance to this patient.

Doctors Name, if different from above

HA Code

I will dispense medicines/appliances to this patient subject to Health Authority's Approval

I am claiming rural practice payment for this patient.
 Distance in miles between my patient's home address and my main surgery is

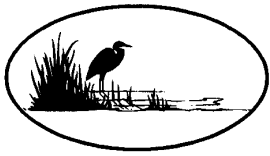
I declare to the best of my belief this information is correct and I claim the appropriate payment as set out in the Statement of Fees and Allowances. An audit trail is available at the practice for inspection by the HA's authorised officers and auditors appointed by the Audit Commission.

Authorised Signature

Name

Date

Practice Stamp



Chilwell Meadows Surgery
Ranson Road, Chilwell, Nottingham, NG9 6DX



NEW PATIENT HEALTH QUESTIONNAIRE

Welcome to the Chilwell Meadows Surgery. We aim to provide high standards of medical care if you are ill, but also to try to keep you fit and well whilst you are with us.

It may take some time for your medical records to arrive from your previous doctor. It helps us to provide the best care for you if we can find out more about you as soon as you register. In order to do this we ask you to fill in this brief questionnaire, and to have a health check with the practice nurse or one of the doctors.

THE INFORMATION YOU GIVE US WILL BE TREATED AS CONFIDENTIAL BY THE DOCTORS AND PRACTICE NURSE

PERSONAL DETAILS:

Full Name and Title	
Date of Birth	
Occupation	
Work Tel Number	
Mobile Number	
E-mail address	
Main Language Spoken	
Ethnic Group	I would/would not like my ethnic group to be recorded in my records. (delete as appropriate) Please record it as:

MEDICATION DETAILS: Do you take any tablets, medicines, inhalers, creams or other treatments on a regular basis? If so, please give details:

Treatment	Dose

Height:

Weight:

Are you allergic to any tablets or medicines? If so, please give details:

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MEDICAL HISTORY: Do you have, or have you had, any of the following conditions? If yes, please give details:			
	No	Yes	Details
Asthma			
Diabetes			
Heart attack or angina			
High blood pressure			
Cancer			
Depression			
Thyroid problems			
Stomach ulcer			
Glaucoma			
Any operations			
Any other illnesses			
FAMILY HISTORY: Do any illnesses run in your family? If so, please give details:			
Illness			
Relationship			
LIFESTYLE:			
<p>Are you a Carer? Yes <input type="checkbox"/> No <input type="checkbox"/> (if so, please ask reception for a leaflet)</p> <p>Do you smoke? (Tick one box only) Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If no have you ever smoked on a regular basis? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>If you do smoke cigarettes, how many per day? (be honest) _____ and for how many years? _____</p> <p>How much alcohol do you drink in an average week? _____</p> <p>How much physical exercise do you do in an average week? (Give details)</p>			

positive



County Health Partnerships

improving health services in your community

Health Visiting Team
Beeston Health Centre
Dovecote House
38 Wollaton Road
Beeston
Nottingham
NG9 2NR

Tel: (0115) 8835500

Dear

Welcome to the Beeston area.

The Health Visiting Team is based at the Beeston Health Centre.
Beeston Health Centre
Dovecote House
38 Wollaton Road
Beeston
Nottingham
NG9 2NR

Drop-in clinics are held at Beeston Health Centre in the Health Education Room on Thursday 9.30am-11.30am – no appointment required.

Drop-in clinics are also held at the following Surestart Centres:

- Chilwell Childrens Centre (On site of Sunnyside School) on Wednesday 9.30am-11.30am
- Beeston Children's Centre (On site of Beeston Fields School) on Friday 10am-11.30am

We like to meet new families as soon as possible. Please help us by completing the form below and handing it to the Practice Receptionist at the Doctor's Surgery. We are looking forward to meeting you and your children and we will contact you to arrange an appointment. If you would like to see a Health Visitor urgently please contact us straight away, or call in at one of the clinics.

With Best Wishes

Health Visiting Team

CHILWELL MEADOWS SURGERY

Child's Health Transfer-in Details Today's date.....

Name of child/children..... Date of Birth.....

..... Date of Birth.....

New Address..... Tel.....

Name of Parents.....

Previous Address.....

Previous Family Dr..... Previous Health Visitor.....

First Language.....

NOTE FOR RECEPTION STAFF: Please return to Health Visiting Team as soon as possible. Thank you.