Under 18's NEW PATIENT ASSESSMENT FORM

Dear Patient/Parent of Patient – We kindly ask that you fill out this New Patient Questionnaire. Please be aware that the questions below may indicate that an appointment is needed with a Nurse or Doctor. Please complete all sections. Thank you.

Name	DOB
Postcode	Sex
Email I consent to email contact from the surgery ☐	Telephone If mobile, I consent to text reminders ☐
Ethnic Group (e.g. British/mixed British, Indian or British Indian, Pakistani or British Pakistani, Irish, White or Black African)	First Language

Do you have a Long-term condition? Please tick if yes.

☐ Asthma
☐ Cardiac history
☐ Behavioural problems
☐ Learning disabilities
☐ Other (please specify) ………

Medicines
Do you take any regular medication? YES / NO
If you live in Rye which chemist would you like to use ☐ Boots ☐ Day Lewis
If you live outside of Rye we will dispense your medication

Allergies
Do you have any allergies or reactions that you are aware of? YES / NO
Please provide details – including what it is and what happens………………………………………………………………
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Smoking status (for patients aged 15-18) –Please tick the appropriate box.
☐ Never smoked ☐ Current Smoker - Age Started ______ per a day_____
☐ Ex-Smoker (date: ___/___/_____)
If you are a current smoker, would you like to stop smoking? YES / NO

Immunisations
Are all immunisations up to date (including HPV for females) YES/NO

Family History
Is there any significant family history; mother/father or siblings YES/NO
If yes, please give details ……