|  |  |  |
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| **Dr S A BRENNAN** MB, ChB  **Dr K DURKAN** MBChB, BSC (Hons), MRCGP  **Dr J L GRAY** BSc, MB, ChB, MRCGP (2013)  **Dr A N MATTOCKS** MBBS, DRCOG, MRCGP (1995)  **Dr E A O’LEARY** BSc, MBChB, DRCOG, DFFP, MRCGP (2011)  **Dr S TAHIR** MBBS, DRCOG, MRCGP (2018)  **Dr S BISHOP** BM BCh, MA, DRCOG, MRCGP (2018) |  | **Bankfield Surgery**  **Huddersfield Road**  **Elland**  **West Yorkshire**  **HX5 9BA**  **Tel: 01422 374662**  **Email: bankfield.surgery@nhs.net**  **www.bankfieldsurgery.org.uk** |

**Patient Health Questionnaire - Children Aged 0-16**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Personal Details** | | | | |
| Name: | | | DOB: | Age: |
| Address: | | | | |
| Home Phone No: | | Mobile no:  Who does this number belong to: | | |
|  | | | | |
| Ethnicity: | | Main Spoken Language: | | |
|  | | | | |
| **Previous GP** | | | | |
| Dr: | | | | |
| Surgery: | | | | |
|  | | | | |
| **Medication** | | | | |
| Please list any medication you are currently taking: | | | | |
|  | | | | |
| **Medical History** | | | | |
| Please list any long term condition e.g. Asthma, Diabetes etc: | | | | |
|  | | | | |
| **Allergies** | | | | |
| Are you allergic to any medicines, substances or foods? Yes No  Please give details: | | | | |
|  | | | | |
| **Immunisations** | | | | |
| Please completeimmunisation status for children under 10 years old: | | | | |
| Triple/polio/HIB: Yes No | Dates: | | | |
|  |  | | | |
| MMR: Yes No | Date: | | | |
|  |  | | | |
| Tetanus: Yes No | Date last given: | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Family History** | | | | | |
| Do any family members have any of the following conditions? **(Please tick all that apply)** | | | | | |
| **Condition** | **Yes** | **Relationship to you** | **Condition** | **Yes** | **Relationship to you** |
| Asthma |  |  | Heart Problems |  |  |
| Cancer |  |  | High Blood Pressure |  |  |
| COPD |  |  | Stroke |  |  |
| Diabetes |  |  | Other (please specify) |  |  |
| Epilepsy |  |  |
|  | | | | | |

|  |  |
| --- | --- |
| **Emergency Contact Details** | |
| **Contact 1** | |
| Name: | |
| Relationship to you: | Next of kin? Yes No |
| Address: | |
| Home Number: | Mobile Number: |
| **Emergency Contact Details** | |
| **Contact 2** | |
| Name: | |
| Relationship to you: | Next of kin? Yes No |
| Address: | |
| Home Number: | Mobile Number: |
| **You should notify the individual(s) you have named above that you have provided us with their information and that we will hold this information within your electronic medical record.** | |

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| **Text and Email** |
| If you do not wish to receive information this way, please ask at reception to complete an Opt Out form. |