## New Patient Questionnaire (Newborn)

Congratulations on the birth of your newborn. We would be grateful if you would complete this confidential questionnaire which we give to every newborn.

Please return this with the GMS1 form so that we can register your new baby.

Thank you.

# Your Child’s Details

Surname

First Name(s)

Title

What name would you prefer us to use when we call you?

Date of birth

NHS Number (If known)

Home Address

Health Visitor (if known)

What is your child’s gender?

What pronouns would you prefer us to use?

⬜ Him / His ⬜ She / Her ⬜ They / Them ⬜ Other:

What is your child’s ethnic group?

What is your child’s language?

If your main language is not English, do you need an interpreter? ⬜ Yes ⬜ No

# Additional Needs

Do you have any other additional accessible needs?

 ⬜ Registered Blind or other visual loss

 ⬜ Require large font ⬜ Do not write to me

 ⬜ Send written information by email

 ⬜ As plain text ⬜ As a PDF

⬜ d/Deaf

⬜ Sign Interpreter Needed ⬜ Lip Read ⬜ Do not phone me

 ⬜ I need a carer or communicator to come with me to appointments:

 ⬜ Name: ⬜ Phone:

 ⬜ Other needs:

*We will endeavour to meet these needs and will discuss them with you at your new patient appointment. Some needs, such as Braille, we are currently unable to provide, though we constantly review how we can better support patients with additional needs.*

# Parent or Guardian Details

### Mother or Parent 1

Surname Title

First Name(s)

Home Telephone

Work Telephone

Mobile Telephone

Relationship to the child

Do you have parental responsibility?

### Father or Parent 2

Surname Title

First Name(s)

Home Telephone

Work Telephone

Mobile Telephone

Relationship to the child

Do you have parental responsibility?

# Birth History:

Birthweight: lb oz or kg

Born at ⬜ Home Hospital (which?)

Was (s) born ⬜ On Time ⬜ Early / Late (by how much?)

Was labour induced? ⬜ No ⬜ Yes

How was your child born ⬜ Normal delivery ⬜ Forceps

 ⬜ Ventouse (Suction)

 ⬜ Caesarian Section:

⬜ Emergency ⬜ Planned

Any problems afterwards? ⬜ No ⬜ Yes If yes, please give details:

# **Family History**

Other than you and your child, who else lives at home:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Age** | **Relationship** | **Occupation / School** |
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Is there a family history of any of the following conditions)

Heart Disease ⬜ Stroke ⬜ High Blood Pressure ⬜ Asthma ⬜ Diabetes ⬜

Other?.............................................................................................................................................

Please give details …………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………….