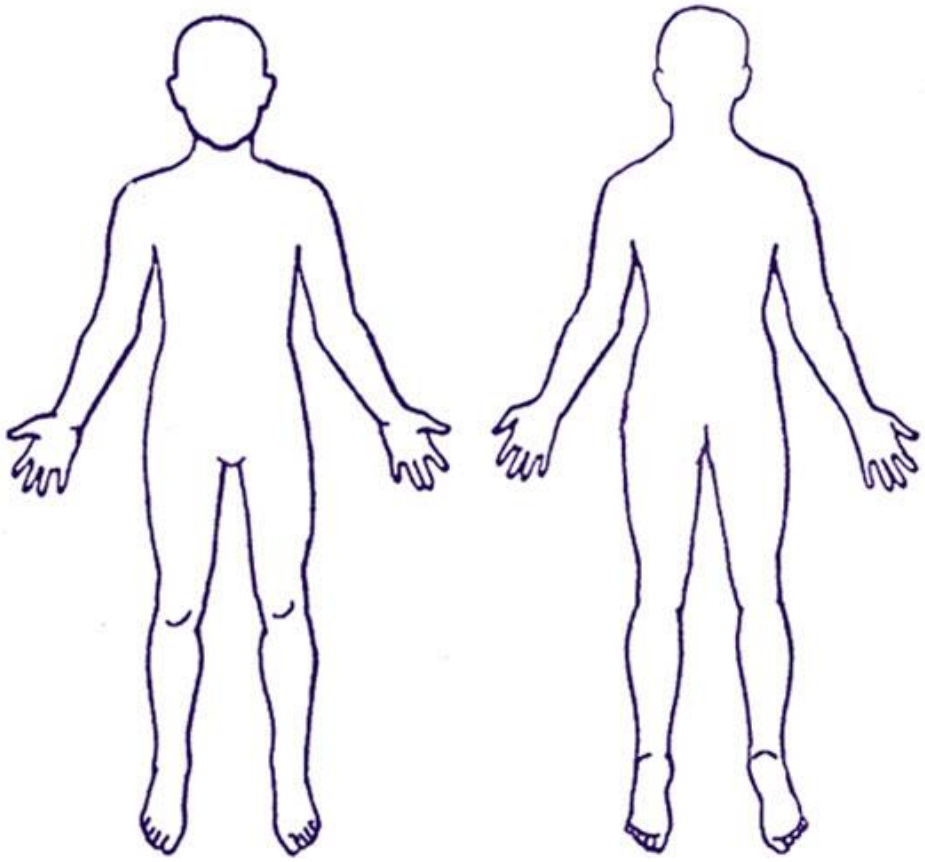
/	English
	# Patient Questionnaire for newly arrived migrants in the UK: Children and Young People
	Everyone has a right to register with a GP. You do not need proof of address, immigration status, ID or an NHS number to register with a GP This questionnaire is to collect information about children's health so that the health professionals at your GP practice can understand what support, treatment and specialist services they may need in accordance with the confidentiality and data sharing policies of the National Health Service. **Competent young people aged under 18 may complete the adult version for themselves.** Your GP will not disclose any information you provide for purposes other than your direct care unless: you have consented (e.g. to support medical research); or they are required to do so by law (e.g. to protect other people from serious harm); or because there is an overriding public interest (e.g. you are suffering from a communicable disease). Further information about how your GP will use your information is available from your GP practice. Return your answers to your GP practice.
	## Person completing

	Who is completing this form: ☐ Child's Parent ☐ Child's legal guardian/carer
	## Section one: Personal details
	Child's full name:
	Child's date of birth: Date_____ Month _____ Year _____
	Child's address:
	Mother's name:
	Father's name:
	Contact telephone number(s):
	Email address:
	Please tick all the answer boxes that apply to your child.
	1.1 Which of the following best describes your child: ☐ Male ☐ Female ☐ Other ☐ Prefer not to say
	1.2 Religion: ☐ Buddhist ☐ Christian ☐ Hindu

	☐ Jewish ☐ Muslim ☐ Sikh ☐ Other religion ☐ No religion
	1.3 Main spoken language: ☐ Albanian ☐ Arabic ☐ Dari ☐ English ☐ Persian ☐ Other ☐ Russian ☐ Tigrinya ☐ Ukrainian ☐ Urdu ☐ Vietnamese
	1.4 Second spoken language: ☐ Albanian ☐ Arabic ☐ Dari ☐ English ☐ Persian ☐ Other ☐ Russian ☐ Tigrinya ☐ Ukrainian ☐ Urdu ☐ Vietnamese ☐ None
	1.5 Does your child need an interpreter? ☐ Yes ☐ No
	1.6 Does your child need sign language support? ☐ No ☐ Yes
	1.7 Who lives in the same household as your child now in the UK? ☐ Mother ☐ Father ☐ Brother(s) How many? _____ What age(s)? _____ ☐ Sister(s) ☐ How many? _____ ☐ What age(s)?_____ ☐ Other ☐ How many? _____
	1.8 Does your child attend nursery or school? ☐ No

	☐My child is under 2 years of age ☐ We have applied for a place but have not yet been allocated a nursery/school ☐I would like information on where I can get support to apply for a nursery or school place ☐Yes – *please give name of nursery or school* _____
	## Section two: Health questions
	2.1 Do you have any concerns about your child? ☐No ☐Yes
	2.2 Is your child currently unwell or ill? ☐No ☐Yes
	2.3 Does your child need an urgent help for a health problem? ☐No ☐Yes
	2.4 Does your child currently have any of the following symptoms? Please tick all that apply ☐Weight loss ☐Cough ☐Coughing up blood ☐Night sweats ☐Extreme tiredness ☐Breathing problems ☐Fevers ☐Diarrhoea ☐Constipation ☐Skin complaints or rashes ☐Blood in their urine ☐Blood in their stool ☐Headache ☐Pain ☐Low mood ☐Anxiety

	☐ Distressing flashbacks or nightmares ☐ Difficulty sleeping ☐ Feeling that they want to harm themselves or give up on life ☐ Other
	2.5 Please mark on the body image the area(s) where they are experiencing their current health problem(s)



	2.6 Was your child born prematurely (delivered early – before 37 weeks/8.5 months of pregnancy)? ☐ No ☐ Yes
	2.7 Did your child have any health problems soon after delivery e.g. breathing problems, infection, brain injury? ☐ No ☐ Yes

	2.8 **New babies only (up to 3 months old):** Has your child had a 6-8 week post delivery health check by a GP (doctor)? ☐ No ☐ Yes
	2.9 Does your child have any known health problems? ☐ No ☐ Yes
	2.10 Does your child have any of the following? Please tick all that apply ☐ Asthma ☐ Blood disorder ☐ Sickle cell anaemia ☐ Thalassaemia ☐ Cancer ☐ Dental problems ☐ Diabetes ☐ Epilepsy ☐ Eye problems ☐ Ears, nose or throat ☐ Heart problems ☐ Hepatitis B ☐ Hepatitis C ☐ HIV ☐ Kidney problems ☐ Liver problems ☐ Mental health problems ☐ Low mood/depression ☐ Anxiety ☐ Post-traumatic stress disorder (PTSD) ☐ Previously self-harmed ☐ Attempted suicide ☐ Other ☐ Skin disease ☐ Thyroid disease ☐ Tuberculosis (TB) ☐ Other
	2.11 Has your child ever had any operations / surgery? ☐ No ☐ Yes
	2.12 Does your child have any physical injuries due to war, conflict or torture?

	☐No ☐Yes
	2.13 Does your child have any mental health problems? These could be from war, conflict, torture or being forced to flee your country? ☐No ☐Yes
	2.14 Does your child have any physical disabilities or mobility difficulties? ☐No ☐Yes
	2.15 Does your child have any sensory impairments? Please tick all that apply ☐No ☐Blindness ☐Partial sight loss ☐Full hearing loss ☐Partial hearing loss ☐Smell and/or taste problems
	2.16 Do you think your child has any learning difficulties or behaviour problems? ☐No ☐Yes
	2.17 Do you have any concerns about your child's growth e.g. their weight/height? ☐No ☐Yes
	2.18 **Babies only:** Is you child experiencing any feeding problems e.g. vomiting, reflux, refusing milk? ☐No ☐Yes
	2.19 Has a member of your child's immediate family (father, mother, siblings, and grandparents) had or suffered from any of the following? ☐Asthma ☐Cancer ☐Depression/Mental health illness

	☐Diabetes ☐Heart attack ☐Hepatitis B ☐High blood pressure ☐HIV ☐Learning difficulties ☐Stroke ☐Tuberculosis (TB) ☐Other
	2.20 Is your child on any prescribed medicines? ☐No ☐Yes –*please list your child's prescribed medicines and doses in the box below* ***Please bring any prescriptions or medicines to your child's appointment*** *Name* | *Dose* |
	2.21 Are you worried about running out of any these medicines in the next few weeks? ☐No ☐Yes
	2.22 Does your child take any medicines that have not been prescribed by a health professional e.g medicines you have bought at a pharmacy/shop/on the internet or had delivered from overseas? ☐No

	☐Yes –*please list medicines and doses in the box below* ***Please bring any medicines to your child's appointment*** *Name* | *Dose*
	2.23 Does your child have allergy to any medicines? ☐No ☐Yes
	2.24 Does your child have allergy to anything else? (e.g. food, insect stings, latex gloves)? ☐No ☐Yes
	## Section three: Vaccinations
	3.1 Has your child had all the childhood vaccinations offered in their country of origin for their age? ***If you have a record of your vaccination history, please bring this to your appointment.*** ☐No ☐Yes ☐I don't know
	3.2 Has your child been vaccinated against Tuberculosis (TB)?

	☐ No ☐ Yes ☐ I don't know
	3.3 Has your child been vaccinated against COVID-19? ☐ No ☐ Yes ☐ 1 dose ☐ 2 doses ☐ 3 doses ☐ More than 3 doses ☐ I don't know
	If there is something relating to your child's health that you do not feel comfortable sharing in this form and you would like to discuss it with a doctor, please call your GP and book an appointment