

NEW PATIENT QUESTIONNAIRE FOR UNDER 16's

Name Date of Birth

Gender:

Name of Parent/Gaurdian

SCHOOLING (please tick appropriate)

Home schooled

☐

Public School

☐

Private School

☐

Do you give KIS Consent ? (Key Information Summary) allows important medical information to be shared with healthcare professionals involved in your care, especially in urgent or out-of-hours situations.

YES / NO

Next of Kin (pls give details address, contact no, relationship):

.....

.....

.....

Is Power of Attorney in Place:

YES / NO

Is Power of Attorney currently active:

YES / NO Date activated:

If yes, please give details:

.....

If there a Guardianship order in place:

YES / NO

If yese, please give details:

.....

Medical History (if not enough space please detail on additional back page)

Previous Serious Illnesses

Operations and dates

.....

.....

.....

.....

.....

.....

Present regular medication (please list name, strength and how often taken)

(if not enough space please detail on additional back page)

Name

Strength

How often taken

.....

.....

.....

.....

.....

.....

.....

.....

.....

Drug Allergies (if not enough space please detail on additional back page)

.....

.....

.....

.....

Smoking Habits (for over 14 years only)

Smoker ☐ Number of cigarettes/cigars/tobacco per day

Non-Smoker

☐

Vapes / E-cigarettes ☐

Family History

Is there anyone in your family who has had (if so at what age)

Heart disease < 60yrs old

☐

Please give details

Name & Relationship to patient if signing on their behalf: