# PATIENT PROFILING QUESTIONNAIRE

To be completed as part of the New Patient Registration Form

Name : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section A) Country of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Section B) Your Ethnic Group:

Please write ethnic origin of child in the space below and tick ONE BOX that suits the ethnic group:

Childs Ethnic Origin: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Language \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnic Groups

|  |  |
| --- | --- |
| WHITE | BLACK or BLACK BRITISH |
|  British Irish Any other White background |  Caribbean African Any other Black background |
| ASIAN or ASIAN BRITISH | MIXED |
|  Indian Pakistan Bangladeshi Any other Asian background |  White and Black Caribbean White and Black African White and Asian Any other mixed background |
| CHINESE or OTHER ETHNIC GROUP |  |
|  Chinese Vietnamese Any other ethnic group |  |
|  I do not wish to state my ethnic background |  |

**Section C) Disability:**

Do you have any disability?

 No Yes (please specify)

# Under 5 Questionnaire - GP Practice

|  |  |  |
| --- | --- | --- |
| Child's First Name: | Family Name: | D.O.B: |

|  |  |  |  |
| --- | --- | --- | --- |
| Male or Female | Date of Registration: | NHS No: | Place of Birth: |

|  |  |  |
| --- | --- | --- |
| Mother's First Name: | Surname: | D.O.B: |

|  |  |
| --- | --- |
| Father's First Name: | Surname: |

|  |
| --- |
| Address (incl. postcode): |

|  |
| --- |
| Previous GP & Address: |

Contact telephone numbers :

|  |  |  |
| --- | --- | --- |
| Mother Home: | Work: | Mobile: |
| Father Home: | Work: | Mobile: |

|  |
| --- |
| If from abroad, please state date of entry into the UK: |

|  |
| --- |
| Does your child have any medical problems that the doctor should know about? If so please list: |

# Under 5 Questionnaire – Health Visitor

|  |  |  |
| --- | --- | --- |
| Child's First Name: | Family Name: | D.O.B: |

|  |  |  |  |
| --- | --- | --- | --- |
| Male or Female | Date of Registration: | NHS No: | Place of Birth: |

|  |  |  |
| --- | --- | --- |
| Mother's First Name: | Surname: | D.O.B: |

|  |  |
| --- | --- |
| Father's First Name: | Surname: |

|  |
| --- |
| Address (incl. postcode): |

|  |
| --- |
| Previous GP & Address: |

Contact telephone numbers :

|  |  |  |
| --- | --- | --- |
| Mother Home: | Work: | Mobile: |
| Father Home: | Work: | Mobile: |

|  |
| --- |
| If from abroad, please state date of entry into the UK: |

|  |
| --- |
| Does your child have any medical problems that the doctor should know about? If so please list: |