# Patient Profiling Form

Practice / GP: …………………………….……………….....…… Date of Birth: ………………………

Patient Name: …………………………….……………….....…… Post Code: ………………………

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**1. What do you consider to be your ethnic origin?**

**Asian or Asian British**
☐ Bangladeshi
☐ Indian
☐ Pakistani
☐ Asian other (please state)

…………………………………………………….……
…………………………………………………………

**White**
☐ British
☐ Irish
☐ White other (please state)

**Black or Black British**
☐ African
☐ Somali
☐ Caribbean
☐ Black other (please state)

…………………………………………………….……
…………………………………………………………

**Other Ethnic Group**
☐ Chinese
☐ Any other (please state)

**Mixed Background**
☐ White and Asian
☐ White and Black African
☐ White and Black Caribbean
☐ Other mixed background (please state)

…………………………………………………….……

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**2. In the clinic, which language do you <u>usually</u> speak and read?**

| Speaking | Reading | | Speaking | Reading | |
|---|---|---|---|---|---|
| ☐ | ☐ | English | ☐ | ☐ | Polish |
| ☐ | ☐ | Albanian | ☐ | ☐ | Punjabi |
| ☐ | ☐ | Bengali | ☐ | ☐ | Russian |
| ☐ | ☐ | Cantonese | ☐ | ☐ | Somali |
| ☐ | ☐ | Farsi | ☐ | ☐ | Spanish |
| ☐ | ☐ | French | ☐ | ☐ | Turkish |
| ☐ | ☐ | Gujarati | ☐ | ☐ | Urdu |
| ☐ | ☐ | Hindi | ☐ | ☐ | Other (please state) |
| ☐ | ☐ | Mandarin | | ………..…………………………… | |

**Thank you for helping us.**

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☐ I do not wish to complete this form.

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If you need this document in a different format please telephone 0117 900 228

WHITELADIES MEDICAL GROUP

Your Health Visiting Team is based at Hampton House Health Centre.
The Child Health Clinic is on Tuesday 12.00-16.00 at Hampton House.

Please complete this form to enable us to obtain your children's health records and then return the form to reception.

| | Name | Date of Birth | Mobile Number |
|---|---|---|---|
| Mother:<br><br>Father:<br><br>Guardian: | ……………….<br><br>………………..<br><br>………………… | ………………….<br><br>…………………<br><br>………………… | ………………….<br><br>………………….<br><br>…………………. |
| | name | date of birth | school/nursery |
| Children: | ……………….<br>……………….<br>……………….<br>……………….. | ……………………<br>……………………<br>……………………<br>…………………… | ………………………<br>………………………<br>………………………<br>……………………… |
| Telephone(home) | | Telephone (work): | |
| Telephone (emergency) | | Email Address: | |
| Present Address:<br><br>Postcode: | | | |
| Previous Address:<br><br>Postcode: | | | |
| Previous Doctor: | | | |
| Doctors Address: | | | |
| Telephone Number: | | | |

IMMUNISATION HISTORY

It is really important that we have up to date immunisation history for your child including dates that the immunisations were given.

| Childrens Names: | | | | |
|---|---|---|---|---|
| 1st DTaP Hib Polio, Pneumococcal | | | | |
| 2nd DTaP Hib Polio, Pneumococcal | | | | |
| 3rd DTaP Hib Polio, Pneumococcal | | | | |
| Booster Hib/Men C Booster | | | | |
| Pre-school booster, 2nd MMR | | | | |

Please do not hesitate to contact your Health Visiting Team on 0117 3302612/3302630 if you need advice before a contact appointment is made for you

HEALTH VISITORS
HAMPTON HOUSE HEALTH CENTRE
ST MICHAELS
COTHAM, BRISTOL BS8 6AU
FAX 0117 3302703

NEWLY REGISTERED FAMILIES

Please complete this form and return to HAMPTON HOUSE so that we are able to maintain accurate records for our families.
Thank you.

Name of GP Practice……………………………………………

| | NAME | DATE OF BIRTH | OCCUPATION/SCHOOL |
|---|---|---|---|
| MOTHER | | | |
| FATHER | | | |
| CHILDREN | | | |
| | | | |
| | | | |

| CURRENT ADDRESS | |
|---|---|
| TEL NUMBER: | HOME:<br><br>MOBILE: |
| DATE OF MOVE | |
| PREVIOUS ADDRESS | |
| PREVIOUS GP: | |