THE WHITE HOUSE SURGERY

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UNDER 16 YEARS OLD NEW PATIENT INFORMATION QUESTIONNAIRE

TITLE:				
FIRST NAME:				
SURNAME:				
DATE OF BIRTH:				
SCHOOL:				
HOME ADDRESS:				
TEL NUMBER(S):	Home:		Mobile:	
FULL NAME OF MAIN CARER & RELATIONSHIP TO CHILD			CONTACT NUMBER:	
Please tick box if you DO NOT wish to receive text alerts ☐				
NAME & ADDRESS OF PREVIOUS DOCTOR:				
ETHNIC GROUP *Tick box*	White ☐	British/Mixed ☐	White/British ☐	Black African ☐
	Black Caribbean ☐	Black Other ☐	Indian ☐	Pakistani ☐
	Chinese ☐	Vietnamese ☐	Nepalese ☐	
	Other *please specify:*			
WHAT IS YOUR FIRST LANGUAGE:				
PLEASE LIST ANY PRESCRIBED MEDICATIONS AND THE DOSAGE, OR ATTACH A COPY OF				

YOUR MEDICATION LIST FROM YOUR LAST DOCTOR:-		
ARE YOU REGISTERED DISABLED?	YES ☐ NO ☐	
IF YES, PLEASE GIVE DETAILS OF YOUR DISABILITY		
MEDICAL INFORMATION *Please list any serious illnesses/operations/accidents and the year they took place:-*		
HAVE YOU EVER SUFFERED OR DO YOU SUFFER FROM ANY OF THE FOLLOWING:- *Tick box*		
Diabetes	YES ☐ NO ☐	
Epilepsy	YES ☐ NO ☐	
High blood pressure	YES ☐ NO ☐	
Heart disease/angina	YES ☐ NO ☐	
Stroke	YES ☐ NO ☐	
Cancer	YES ☐ NO ☐	
Eye problems	YES ☐ NO ☐	
Depression/mental health problems	YES ☐ NO ☐	
Asthma or COPD	YES ☐ NO ☐	
Thyroid problems	YES ☐ NO ☐	
IF YES, PLEASE GIVE DETAILS:-		
ARE YOU ALLERGIC TO ANY MEDICINES AND, IF SO, WHAT?		
IMMUNISATIONS, PLEASE GIVE DATE WHEN THESE VACCINATIONS WERE GIVEN. YOU CAN FIND DETAILS IN THE RED BOOK.		
1st DTP/Polio	2nd DTP/Polio	3rd DTP/Polio/1st Hib
1st Hib	2nd Hib	3rd Hib
1st Men C	2nd Men C	3rd Men C
Booster Hib	MMR	Pre School Booster MMR

ORGANISATIONS THE CHILD IS OPEN TO? PLEASE GIVE KEY WORKERS DETAILS.

Early Help ☐

Social Services ☐

Children's Mental Health ☐

Others:

Failure to complete this form correctly may result in a delay in your registration being processed.

Once you have completed this form, please hand it back in at Reception. Thank you.