NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE (under 16)

(NB all information supplied will be recorded in your confidential medical records)

Forename: ………………………………………Surname: ……………………………………

NHS number (if known): ............................................................................

Date of Birth: …………………………

Address: ………………………………………………………………………………………………

……………………………………………………………….…………Postcode: ....………….….

Home Tel: ………………………………………….Mobile: ………………………….……………

Ethnicity: ………………………………………………………………………………………………

Gender: ……………………………………………………………………………………………….

**Past Medical History**

Please give details of any treatments/medical conditions:

…………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………

**Medication**

Please give details of any medication which you take (prescribed or otherwise):

|  |  |
| --- | --- |
| **Name of drug** | **Dosage** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Immunisations** (please give copy to reception when registering)

|  |  |
| --- | --- |
| **Name** e.g MMR | **Date** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Allergies**

Do you have any allergies? *Yes*/*No*

If Yes, please give details:

…………………………………………………………………………………………………………………

***Thank you for completing this questionnaire.***