COLWALL SURGERY

NEW PATIENT REGISTRATION INFORMATION – CHILD

To the Parent / Carer:

To register with the Practice please complete this questionnaire as fully as possible. The information will help the doctor to make an initial assessment of your child's health which will help them for future treatment.

Surname: …….. Previous Surname(s) if applicable:…….

Forename(s): ……..

Date of Birth: …… Sex: ……..

Address:……

…… Postcode:…….

Home Tel:…… Mobile:……

Email address:…….

What is your child's ethnicity? ……..……

What is your child's first language? …….

Country of Birth:…… Place of Birth:…….....

Previous Address:……

……Postcode:……..

Date of registration…….

Name of Next of Kin:……

Relationship to your child: …….

Address of Next of Kin:……

……..…

Contact Telephone Number (Home)……..……(Mobile)…….…..

Previous GP Details

Previous GP's Name and Address:……

……..

PTO

COLWALL SURGERY

HEALTH QUESTIONNAIRE – CHILD

Previous medical history

Does your child have any medical conditions that we should know about?

……

Has your child had any operations?

:……..

MEDICATION

Please give details of any medication which your child takes (prescribed or otherwise):

Name of drug: ……

Dosage: ……

Name of drug: ……..

Dosage: ……

Name of drug: ……..

Dosage: ……

ALLERGIES

Is your child allergic to medicines or anything else? Yes / No

If yes, please give details:……..

……..

For Office Use Only:

Date of registration:

	Date:
Registered on the System	
Recorded in the 'ON' Book	
Notes received	
Notes summarised	