Date:______________________________

New Patient Questionnaire – Under 16

Please complete the questionnaire as fully as possible.

SURBITON
Central Surgery

Master/Miss/ (please circle)

Surname: ____________________

First names: ____________________

____

NHS No: ____________________

Male/Female (please circle)

Date of Birth:______/______/______

Home Tel - ____________________

Parents details:

Please complete overleaf

Home Address

____

____

____

____

Post Code:

____

Mobile No

____

Email ____________________

By providing your mobile number and email you consent to us contacting you this way. No clinical details will be sent.

Ethnicity (please circle)

White British
White Irish
White Other

Black Caribbean
Black African
Black other

Indian
Pakistani
Chinese

Mixed-
White/Black Caribbean
White/ Black African
White/Asian

Other (please specify)

____

First spoken language

Next of Kin:
Name: ____________________

Address: ____________________

____

Tel No: ____________________

Personal Medical History: please list any serious illnesses/Operations/accidents) and the year they took place

____
____
____
____
____
____
____
____

Immunisation History (please supply dates – dd/mm/yyyy)

Primary Course Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae type b (DTaP/IPV/Hib)

Dose 1:_____/_____/______Dose 2:_____/_____/______

Dose 3:_____/_____/______

Meningitis C- Dose 1:____________Dose 2:____________

Hib Dose 4: ____________________

Pre-School Booster: ____________________
(Diphtheria, tetanus, pertussis (whooping cough) and polio)

MMR (measles/mumps/rubella) dose 1:______________

MMR (measles/mumps/rubella) dose 2:______________

Pneumococcal (PCV): Dose 1:____________Dose 2:______________

Please bring in your red book/vaccination record

Drugs and Medicines			
Please specify all drugs or tablets that you take regularly (Please supply old repeat prescription slip if available)			
Name	**Dose**	**Name**	**Dose**
Are you allergic to any drugs or medicines			Yes/No
If yes, which ones			

Do you need help with communication	Tick if yes
Large print	
Braille	
Induction loop	
British Sign Language	
Other (give details)	

____

Are you a carer If yes, please ask for a Carer's Registration Form	Tick if Yes
A carer is a person who is caring for someone who needs support because of age, frailty or long term medical, physical or learning disability; without being paid for the care they give.	

Parent/Guardian Details

	Home telephone number	Mobile Number*	Email*	Tick if a patient at Central
Mum				
Dad				
Legal Guardian				

* By giving mobile and email details you consent to us contacting you by these methods.
No clinical details will be sent to you by these methods.

Who do you (the child) live with ____