



Crown House Surgery

Retford Primary Care Centre North Road Retford Notts DN22 7XF

Tel: 01777 703672 Fax: 01777 710534

Under 16 New Patient Questionnaire

ID Checked

Type of ID.....

Would you please complete the questionnaire below. It will help us to provide medical care until we receive your child's medical records from their previous doctor.

Child's Name: Date of Birth:

Ethnic Origin

Please tick one box that most reflects your background:

- | | | | | | |
|---------|--------------------------|-----------------|--------------------------|---------------------------|--------------------------|
| British | <input type="checkbox"/> | Irish | <input type="checkbox"/> | Polish | <input type="checkbox"/> |
| Turkish | <input type="checkbox"/> | Black Caribbean | <input type="checkbox"/> | White Caribbean | <input type="checkbox"/> |
| Indian | <input type="checkbox"/> | Pakistani | <input type="checkbox"/> | Bangladeshi | <input type="checkbox"/> |
| Chinese | <input type="checkbox"/> | Asian | <input type="checkbox"/> | Other Please state: | |

* Next of Kin.....

Name of Health Visitor:

Address of Health visitor:

Please give details of any previous major illnesses or operations and any current health problems:

.....
.....
.....

Current Medication:

.....
.....

* Family Medical history

Has a close relative (mother, father, sister, brother) suffered from any of the following?

Please note down their relationship

- | | | | | | |
|---------------------|--------------------------|-------|----------------|--------------------------|-------|
| Diabetes | <input type="checkbox"/> | | Asthma | <input type="checkbox"/> | |
| Stroke | <input type="checkbox"/> | | Blood pressure | <input type="checkbox"/> | |
| Heart Attack <60yrs | <input type="checkbox"/> | | Cancer | <input type="checkbox"/> | |

* Are you adopted: Yes No

Immunisations:

Baby Immunisations starting around 8 weeks of age

	1 st Date given	2 nd Date given	3 rd Date given
Diphtheria, Tetanus, Polio Pertussis* (whooping cough), HIB. Meningococcal C**			

*Did your child receive the whooping cough part of the triple vaccine? YES/NO

**Was Meningococcal vaccine given with the three triple vaccines? YES/NO

if NO has your child received a single Meningococcal vaccination? YES/NO

If a single Meningococcal vaccine has been given please give the date

Immunisations Age 1 to 16 years

MMR, HIB, Men C, Pneumococcal (Age 12-13months)

Date Given

Diphtheria, Tetanus & Polio (Pre-School Age 4 to 5 years)

MMR Booster (Age 4 to 5 years)

Diphtheria, Tetanus & Polio Booster (Age 15 to 16 years)