East Calder Medical Practice

New Patient Questionnaire - Child

Name:		Date Of Birth:				
Address:						
Home Telephone No:		Mobile:				
Next of kin :	Relationship:		Contact Details:			
Have you ever been registered at East Calder Medical Practice before? If so, under what name were you registered & when? _Yes / No						
Ethnicity — Please tick one box only.						
White Mixed Asian or Asian Brit			er Ethnic roups	Decline to provide Ethnic Group		
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MEDICAL BACKGROUND ALLERGIES - Do you have any allergies? If YES please list below:						
Drug Related Allergies:						
Non-Drug Related Allergies:						

Are you taking any medication? Yes / No (please circle)

(If you have a repeat prescription slip from your previous Practice please attach)

Please list any serious illness, operations or conditions:					

Immunisation History

Health History:

Immunisation	Approximate Date Given

Thank you for your assistance in completing this Questionnaire. Please hand it back with your Registration Form. If you are taking any regular prescribed medication you will require a GP consultation.