UNDER 16'S

REDGATE MEDICAL CENTRE

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May we take this opportunity to welcome you to Redgate Medical Centre and ask that you carefully read and complete the attached questionnaires listed below:

1. New Patient Health Questionnaire (Please complete all fields)
2. Medication Request (Only complete if you are currently taking medication)
3. If you come from abroad and have not registered in the UK before, please bring proof/copy of Immunisations.

ONCE COMPLETED, PLEASE HAND THE COMPLETED FORMS TO THE RECEPTIONIST WITH A FORM OF IDENTIFICATION OR CONFIRMATION OF YOUR CURRENT ADDRESS
We will not be able to process your registration without any of the above

Thank you for your co-operation

TO BE COMPLETED BY THE RECEPTIONIST

New Patient Health Check Arranged ………………………………………………

Practice Booklet Given ………………………………………………

Receptionist Signature ………………………………………………

Date Forms Completed ………………………………………………

Date Patient Registered ………………………………………………

UNDER 16'S

REGISTRATION - PATIENT HEALTH QUESTIONNAIRE (CHILDREN UNDER 16)

Please complete this form on behalf of your child as fully as possible, as we are unable to complete your registration without this information

Surname …………………………………………………….……… Forenames ……………………………………………………….

Previous Surname(s) (if any) ………………………………….. NHS No: ………………………………………………………….

Date of Birth ……………………………………..………. Sex …………..……………………………………………………..

Address ……………………………………………………………………………………..…………………………………….

…………………………………………………………………………………………………..…………………………….…..

Post code ……………………………………..……………. Telephone Number ……………………………………………..

PREVIOUS ADDRESS ……..…..

……

PREVIOUS GP ……….

Place of Birth ……….

Parent/Guardian/s Full Names ………………………………………………………………………………………………….

Parent/Guardian/s Address if different than patient's current Address ……………………………………………………..

……..

What is your first language?

Ethnic Groups **(please tick one option and delete as appropriate)**

☐ White – British/Irish/Other – please specify ……………………………………………………………………………….

☐ Black – Caribbean/African/Other – please specify ………………………………………………….…………………….

☐ Asian – Indian/Pakistani/Chinese/Other – please specify …………………………………….…………………………..

☐ Mixed – White & Black Caribbean/White & Black African/White & Asian/Other mixed – please specify …………………………...

☐ **I DO NOT WISH TO GIVE THIS INFORMATION**

Do you currently smoke? Yes/No If 'Yes' how many cigarettes a day …………………………………………………..……..

If no, have you ever smoked? Yes/No or ounces of tobacco a week ……………………………………………...…….….…….

Please let us know is you would like smoking cessation advice

Did you have any problems at or around the time of birth? …………………………………………………………..……

Please list any health problems, serious illnesses, accidents, operations or disabilities: ……………………………….…

………..

Are you registered disabled? Yes/No If yes, please give details of your disability ………………………….…………

…….…….

Height ……………………………………………………..   Weight ………………………………….…………………...

Immunisations
For children aged six and below, please give dates (or just a tick if dates are not known):

	First	**Second**	**Third**	**Pre-School**
Diphtheria, Tetanus, Polio	……..………	…..…………	……..………	…..…………
Pertussis (whooping cough)	……………..	………..……	……………..	……………..
Measles	……………..			
or				
MMR	……………..			

For Females Only

Rubella (German Measles)	……………
HPV (Human Papilloma Vaccine	……………

Medicines (Please list any medications taken regularly) ………………………………………………………………….

……….

Are you allergic to any medicines and if so which? …………………………………………………………..…………

……….

Do you have any special milks or foods? ……………………………………………………………………………….

Do you suffer from any Allergies?
……….

If you suffer from Asthma, are you aware of any triggers that increase your asthma symptoms …………………………..

………..….

For Children with Chronic Disease Only (e.g. asthma, diabetes etc.)

Have you had a 'flu vaccination? Please enter date or 'never' ………………………………………….……………………..

Have you had a pneumococcal vaccination? Please enter date or 'never' …………………………………………………...

Preferred Pharmacy

LLOYDS: Redgate ☐ Taunton Road ☐ Somerset Bridge ☐ North Petherton ☐ Victoria Park ☐

Superdrug ☐ Sainsburys ☐ Boots ☐ Quayside ☐

Parent/Guardian Signature ………………………………………………………….. Date ………………………………

Revised – March, 2010

PLEASE COMPLETE THIS PAGE IF YOU ARE CURRENTLY TAKING MEDICATION

Date:

Patients Full Name:

Patients Date of Birth:

Patients Previous Address:

Date of last prescription (if known):

Name & Address of Previous Surgery:

Telephone Number of Previous Surgery:

Fax Number of Previous Surgery: