

# WESTCROFT HEALTH CENTRE

## NEW PATIENT QUESTIONNAIRE

*(For patients who are under 16 years)*

All information provided is confidential and will help identify any medical help you may need

### CHILD'S DETAILS

Surname:	Forename(s):
Date of birth:	NHS number (if known):
Address:	
	Post Code:
Home Tel No:	Mobile Tel No:
Emergency Contact Name and Tel No:	
Ethnic Origin:	First Language:
Name of school/college:	
<i>Please inform the surgery of any changes</i>	

### CHILD'S HEALTH

Have you had any operations or serious illnesses? <i>If yes please list below with the date of occurrence:</i>	
Do you have any severe allergies (e.g. foods, latex, drugs etc)?	
Do you suffer from asthma?	Date of diagnosis:
Do you have diabetes?	Date of diagnosis:
Do you suffer with epilepsy?	Date of diagnosis:

### IMMUNISATIONS

DtaP/Hib/Polio	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>
Pneumococcal	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>
Meningitis C	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>
Hib/Men C Booster			
MMR	1 <sup>st</sup>	2 <sup>nd</sup>	
Preschool Booster			
BCG			
DtP Booster			
HPV	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>

### INFORMATION

**Carers** - Are you a carer for a dependent relative - Yes / No

**Medication** - If you require repeat medication please make an appointment with the doctor, please let us have a list of all medications that you are currently prescribed.

Parent/Guardian Signature..... Print Name.....

Date.....

The doctors retain the right to accept or refuse any patient on to the surgery NHS list

