**CONFIDENTIAL MEDICAL REGISTRATION FORM**

ROWNER SURGERY

**CHILDRENS QUESTIONNAIRE (0 TO 15 YEAR’S )**

**PLEASE COMPLETE AS MANY QUESTIONS AS POSSIBLE ABOUT YOUR CHILD**

**PLEASE NOTE YOUR NAMED ACCOUNTABLE GP IS DR GOHER ALTAF UNLESS YOU ARE INFORMED OTHERWISE**

**Please complete all pages in FULL using BLOCK capitals**

Surname

First Names (in full)

**Title**: 🞏 Miss 🞏 Master 🞏 Male 🞏 Female

Date of Birth (day/month/year)

NHS Number 🞏🞏🞏 🞏🞏🞏 🞏🞏🞏🞏

Town & country of Birth 

Address

Post Code:

Telephone number:

Mobile number:

Email address:

Are you happy for us to contact you by telephone 🞏Yes 🞏No By text 🞏Yes🞏No By email 🞏Yes🞏No

Does your child have any special communication requirements ie – difficulty with hearing, speech or sight 🞏Yes🞏No

Is the Childs Parent or Guardian a Military Veteran 🞏Yes🞏No

Is the Childs Parent or Guardian a serving member of the HM Armed Forces 🞏Yes🞏No

**General Medical History…..**

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

|  |  |  |
| --- | --- | --- |
| **Condition** | **Year diagnosed** | **Ongoing** |
|  |  | Yes/No |
|  |  | Yes/No |
|  |  | Yes/No |
|  |  | Yes/No |
|  |  | Yes/No |
|  |  | Yes/No |

**Family History…..**

Have any close relatives (*father, mother, sister, brother only*) ever suffered from any of the following: (please indicate who in the boxes)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Heart attack | Stroke | Diabetes | High blood pressure | Asthma | Glaucoma | Cancer |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

**Smoking**

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Smoking related questions to be completed for all patients aged 14 and over.

Have you ever smoked **Yes/No**

Ex-Smoker Date stopped ……………

Current smokers , Please state amount smoked daily:

Cigarettes [ ] number

Cigars [ ] number

Pipe [ ] ounce

**Allergies ……**

Please list any allergies your child has:

|  |  |
| --- | --- |
| **Allergy** |  |
|  |  |
|  |  |
|  |  |

**Please list any medication your child takes on a regular basis and make a GP appointment for them**

**Regular medication ……**

|  |
| --- |
| **Name of medication** |
|  |
|  |
|  |
|  |
|  |
|  |

**Ethnicity ……**

**vej**

Please indicate your childs ethnic origin:

🞏 British or mixed British 🞏 Irish 🞏 African

🞏 Caribbean 🞏 Indian 🞏 Pakistani

🞏 Bangladeshi 🞏 Chinese 🞏 Other please state

🞏 Decline to state

**VACCINATIONS**

**vej**

|  |  |
| --- | --- |
| Vaccination | Date given |
|  |  |
|  |  |
|  |  |
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