New Patient Questionnaire under 16

|  |
| --- |
| **Have you previously been registered with Catshill Village Surgery****YES ⁯ NO ⁯** |

**Administration Details:**

|  |
| --- |
| **Full Name:** |

|  |
| --- |
| **Date of Birth:**  **Sex: M ⁯ F ⁯** |

|  |
| --- |
| **Address:** |

|  |
| --- |
| **Contact Telephone: Home: Mobile:** |

|  |
| --- |
| **Parent/Guardian Contact Details:** |

|  |
| --- |
| **Ethnic Origin:** |

**Thank you for completing this form. By signing the form below you are consenting to your clinical information being shared among other Health Care Professionals with the practice as required.**

**Date: Parent/Guardian Signature:**

|  |
| --- |
| **Date Booked for NPC:** |

**PLEASE BRING A SPECIMEN OF URINE IN A CLEAN CONTAINER TO YOUR NEW PATIENT CHECK**

**We would be grateful if you would complete this questionnaire before seeing us.**

|  |
| --- |
| **Any drug allergies: YES/NO****Any other allergies: YES/NO****Current Medicines: (Please include dose if known)** |

|  |
| --- |
| **Past Medical History:****Details of Any Operations:** |

|  |
| --- |
| **Family History: Have you or any of your family had any of the following?****Diabetes YES ⁯ NO ⁯****High Blood Pressure YES ⁯ NO ⁯****Heart Attack YES ⁯ NO ⁯****Stroke YES ⁯ NO ⁯****Epilepsy or fit YES ⁯ NO ⁯****Asthma YES ⁯ NO ⁯****Thyroid Disease YES ⁯ NO ⁯****Glaucoma YES ⁯ NO ⁯****Cancer YES ⁯ NO ⁯****Any Congenital Diseases YES ⁯ NO ⁯****Please give details of any condition you have answered “YES” to** |

|  |
| --- |
| **Do you smoke? YES ⁯ NO ⁯ If “YES” how many per day?****Would you like assistance to stop? YES ⁯ NO ⁯****Have you ever smoked? YES ⁯ NO ⁯**  |

**PLEASE ATTACH DETAILS AND DATES OF ALL IMMUNISATIONS**