New Patient Questionnaire under 16

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

**Administration Details:**

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| **Full Name:** |

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

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| **Address:** |

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

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

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| **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:**

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| **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.**

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

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

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| **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** |

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| **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**