STONEHAVEN MEDICAL GROUP

**NEW PATIENT REGISTRATION FOR CHILDREN UNDER 16**

You have requested to join our practice and it may be some time before your medical records reach us. To help us provide the best service we can please complete this questionnaire which will become part of your medical record.

|  |  |  |
| --- | --- | --- |
| **Surname:** | **Forenames:** | **Date of Birth:** |
| **Present Address:****Post Code:** | **Contact Telephone Numbers:**Home…………………..……..……......... Mobile…………………....…………...Other…………………….………Can we contact you by text message with appt reminders, etc? Yes / No  |
| **Mother’s Full Name** | **Father’s Full Name** |
| **Next of Kin: name, contact number, and relationship to child** (please keep Surgery informed if NOK changes) |
| **Are you allergic to any medicine?** | **Other known Allergies:** |
| **Please indicate your preferred pharmacy with a tick in the box:** | Charles Michie, 24 Market Square, Stonehaven  | Boots, 2-6 Evan St, Stonehaven | Newtonhill Pharmacy, 1 Skateraw Rd, Newtonhill |
| **Which ethnic group do you belong to? (please tick one box)** |
| White |  |  | Mixed |  |
| Black or Black British |  | Chinese |  |
| Asian or Asian British |  | Other Ethnic Group |  |

**Has your child had any serious illnesses, accidents or operations since birth? If yes please list below with the hospital if applicable**

|  |  |
| --- | --- |
| **Year** | **Condition/Operation** |
|  |  |
|  |  |
|  |  |
|  |  |

**Has your child had any of these illnesses? (Please circle)**

|  |  |  |  |
| --- | --- | --- | --- |
| Chickenpox | Yes / No | Mumps | Yes / No |
| German Measles Rubella | Yes / No | Measles | Yes / No |

**MEDICATION:**

|  |
| --- |
| **Does your child take any tablets, medicines or inhalers at present? Yes / No If yes what are they?** |
|  |
|  |
|  |
|  |

**CHILDREN’S IMMUNISATIONS: Please give dates**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Diphtheria | Tetanus | Pertussis | Polio | HIB | Rotavirus | Pneumococcal | Men C | MMR |
| 1st |  |  |  |  |  |  |  |  |  |
| 2nd |  |  |  |  |  |  |  |  |  |
| 3rd |  |  |  |  |  |  |  |  |  |
| Booster |  |  |  |  |  |  |  |  |  |
| Booster |  |  |  |  |  |  |  |  |  |

**OTHER IMMUNISATIONS: (Please give dates/details of any further immunisations)**

|  |  |
| --- | --- |
| Date | Type of Vaccination |
|  |  |
|  |  |
|  |  |
|  |  |

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