NEW PATIENT (UNDER 16 YRS)

PLEASE COMPLETE THIS FORM CLEARLY IN CAPITAL LETTERS USING BLACK INK

PERSONAL DETAILS

YOUR NHS NUMBER:

SEX: Male / Female

SURNAME

MOTHER'S SURNAME

(if different from above)

FORENAME(S)

DATE OF BIRTH

TOWN & COUNTRY OF BIRTH

YOUR SCHOOL

ETHNIC ORIGIN

CONTACT DETAILS

NO & STREET

TOWN

COUNTY

POST CODE

HOME PHONE

MOBILE PHONE

EMERGENCY CONTACT NAME

EMERGENCY CONTACT'S PHONE

YOUR SCHOOL

SOCIAL WORKER? Y/N IF Y who?.....

PREVIOUS GP

GP's Name

Practice Name

Practice Address

Practice Telephone

THE MOUNTWOOD SURGERY

Welcome to our surgery

As part of our commitment towards improving health we expect:

- *all children under 2 years old to be vaccinated against polio, diptheria, tetanus,whooping cough, HIB, meningitis C, measles, mumps & rubella.*
- *all children should receive pre-school booster vaccines for polio, diptheria, tetanus,whooping cough, measles, mumps & rubella.*

appointment with our nurse as soon as possible.

- *we use and recommend the combined MMR vaccine in line with clinical evidence & government recommendations.*

YOUR HOUSEHOLD

Please list all family & ALL OTHER members living with you.

Name	*DOB*	*their relationship to you (e.g. father, sister,etc)*
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

PAST & PRESENT MEDICAL HISTORY

Include hospital admissions, operations, accidents, & chronic or serious illnesses

Condition	*Month / Year*
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	

ALLERGIES

List any reactions to drugs, plasters, foods, etc

What triggers it? *Description of reaction*

1.

2.

3.

YOUR MEDICATION

List your regular medicines including any over the counter or complimentary medicines

1.

2.

3.

4.

5.

6.

YOUR IMMUNISATIONS

Have you had a FULL COURSE of the usual childhood immunisation given?

YES / NO / Don't know

If NO, state which immunisation not given & why

.....reason?.....

.....reason?.....

Have any of the immunisations ever been given by a private service or given outside this country?

YES / NO / Don't know

If YES, state which immunisation & where

.....where?.....

.....where?.....

PLEASE ATTACH A COPY OF ANY IMMUNISATION RECORDS THAT YOU MAY HAVE

YOUR PRESENT HEALTH STATUS

Do you smoke? N/Y *if Yes, How many/day?.....*

Do you drink alcohol? N/Y *if Yes, units/wk .....*

Exercise every week *Light / Moderate / Vigorous*

I feel I am.... *underweight / just right / overweight*

Prior to joining us have you been attending any:

Nurse Clinic at your previous GP's? Y / N

If so, what for.....

If so, what for.....

Hospital Clinics? Y / N

If so, what for.....

If so, what for.....

Any other health professional? Y / N

If so, what for.....

THANK YOU FOR COMPLETING THIS FORM

For Official Use Only

Please send appointment for the following clinic(s)

1.

2.

3.

Notes:

☐ *Data transferred to EMIS*

☐ *For scanning into records*