Today's Date:

Abbey Meads	
Crossroads	
Penhill	

Abbey Meads Medical Group
New Patient Registration Form – Child (up to 16 yrs)

Please complete this confidential questionnaire (one for each member of the family to be registered with the Practice).

Please complete in BLOCK CAPITALS and tick the boxes as appropriate.

Please bring your passport, driving licence and a council tax/utility bill to confirm your date of birth, address and entitlement to NHS treatment.

<table>
<tr><td colspan="2">First Name:</td><td colspan="3">Surname:</td><td>NHS Number:</td></tr>
<tr><td colspan="3">Mr / Mrs / Miss / Ms / Other……..</td><td colspan="2"></td><td>Telephone Number:</td></tr>
<tr><td colspan="3" rowspan="4">Address and Postcode</td><td colspan="2"></td><td>Mobile Number:</td></tr>
<tr><td colspan="2"></td><td>E-mail Address:</td></tr>
<tr><td colspan="2"></td><td>Next of Kin:</td></tr>
<tr><td colspan="2"></td><td>Next of Kin Contact Number:</td></tr>
<tr><td colspan="2">Date of Birth:</td><td colspan="3">Previous name & surname if different:</td><td>Town & Country of Birth</td></tr>
<tr><td>Marital Status:</td><td></td><td>Gender:</td><td>Male:</td><td>Female:</td><td rowspan="2">Name of Primary Carer</td></tr>
<tr><td colspan="5"></td></tr>
<tr><td colspan="5">Mothers name, date of birth and address (if different to the child's)</td><td>Fathers name, date of birth and address (if different to the child's)</td></tr>
<tr><td colspan="5">Previous Address in UK including Postcode</td><td>Previous Doctor including address:</td></tr>
</table>

Previous Health Visitor (if applicable)	Previous School Nurse (if applicable)
Present School	**Previous Schools**
If you are from abroad **Your first UK address where registered with a GP** **Date you first came to live in the UK:**	**If previous resident in the UK** **Date of leaving:**

Your height:	**Feet / inches**	**cm**	**Your weight:**	**Stones / lbs.**	**kg**

Your Religion:	**C of E**	**Catholic**	**Other Christian (state)**	**Buddhist**	**Hindu**	**Muslim**
	Sikh	**Jewish**	**Jehovah's Witness**	**No religion**	**Other religion (state)**	

Your Ethnic Origin: (select one)	**White (UK)**	**White (Irish)**	**White (Other)**
Caribbean	**African**	**Asian**	**Other Mixed Background**
Indian / Brit Indian	**Pakistani / Brit Pakistani**	**Bangladeshi / Brit Bangladeshi**	**Other Asian Background**
Other Black Background	**Chinese**	**Other**	**Ethnic Category not stated**

Your main or 1st language Spoken / Understood: (select one)	**English**	**Hindi**	**Gujurati**	**Urdu**	**Bengali /Sytheti**	**Punjabi**
Polish	**Ukrainian**	**French**	**German**	**Spanish**	**Other: (Please Specify)**	

Smoking, Alcohol Consumption and Exercise if Child is 14 years plus:					
Are you currently a smoker?	**Yes**	**No**	**Have you ever been a smoker?**	**Yes**	**No**

If so, how many cigarettes / cigars / tobacco do you smoke in a week?		**How much alcohol do you drink in a week (Units)?** *(One unit = 1 small glass of wine, a single measure of spirits, or 1/2 a pint of beer)*	
If you are a smoker and want to stop, please ask for information about local smoking cessation services.			

How often do you exercise?	**No. times per week**	**Type(s) of exercise:**	

Your Medical Background:

What illnesses have you had & When?	
What operations have you had and When?	
Do you have any medical problems at present?	
Please list any tablets, medicines or other treatments you are currently taking: (incl. dose + frequency)	

Are you able to administer your own medicines?	**Yes**	**No – please detail specific issues (e.g. swallowing, opening containers)**

Are there any serious diseases that affect your Parents, Brothers or Sisters (tick all that apply)	**Diabetes**	**Heart Attack**	**Heart attack under age of 60**	**Bowel Cancer**
	Breast Cancer		**High Blood Pressure**	**Asthma** / **Stroke**
	Thyroid Disorder		**Any other important Family Illness?**	

What immunisations have you had? (please tick all that apply) If red book is available, please supply	**Diphtheria**	**Measles**	**German Measles**	**Tetanus**	**Polio**	**MMR**
	Whooping Cough		**Pre-school booster**	**Triple vaccine (Diphtheria, Tetanus & Pertussis) – 3 doses**		

Specific Needs:

Please detail below any specific needs you have so the Practice can ensure they are identified and accommodated by taking the appropriate action:

Please state any Sensory Impairment you have (i.e. Speech, Hearing, Sight):	

Are you an 'Assistance Dog' User?	
Please state any Physical disabilities you have:	
Please state any Mental disabilities you have:	
Please state any requirements you have to be able to access the Practice premises	
Please state any Religious or Cultural needs:	
Do you require the help of a Translator / Interpreter?	
Please state any specific nutritional requirements you have:	
Please state any allergies and sensitivities you have:	
Please state any phobias you have:	
If you are a Carer, please state the name / address / phone number of the person you care for:	**Person Cared For Contact Details:**

Summary Care Records.

The NHS are changing the way your health information is stored and managed.
The NHS Summary Care record is an electronic record of important information about your health.
It will be available to health care staff providing your NHS Care. An information pack has been provided.

Are you happy to have a Summary Care Record?	**Yes**	**No**	**More Time Required to decide:**

Patient Signature:		**Signature on behalf of Patient, if child under 16 yrs:**	

Thank you for completing this form

For more information about the services we offer, please refer to our Practice Leaflet or see our website: www.abbeymeadsdoctors.co.uk