# WELCOME TO BROUGHSHANE MEDICAL PRACTICE

## New Patient Children’s Questionnaire (Aged 16 and under)

Please answer the following questions as fully as you can, this will help us in treating you whilst waiting for your medical records. It is necessary for each member of the family to complete a questionnaire prior to registration. All answers will be treated in strictest confidence.

**Patient Details**

**Full name (Mr/Miss)**

**Date of birth**

**Address**

**Postcode Home No**

**Work No Mobile No**

**Contacting you**

***It is your responsibility to update us with any change of mobile number in the future***

**Town & Country of Birth**

**Dates of Children’s Immunisations**

DTP & Polio/Hib/Men C – 1st

2nd

3rd

Measles/MMR Given by GP/Non NHS Clinic

Any other vaccines

Influenza

**Medical History**

Have you had any serious illness, operations or stays in hospital ( Please give brief details with dates)

Please list any tablets, medicines or inhalers that you are currently prescribed, including their doses

Are you receiving a special diet? Please give details

Are you at present undergoing any medical investigations or awaiting any surgical operations?

Have any of your close relatives had important illnesses, e.g. diabetes, high blood pressure, mental illness, heart problems, stroke, cancer etc?

**Allergies**

Do you have any allergies, e.g. Penicillin, pollen, Elastoplast?

**Register**

Are you on the Child Protection Register **Yes No**

Are you classed as a looked after child **Yes No**

**Other Information**

Is there any other information you feel is relevant?