LADYWELL MEDICAL CENTRE WEST
Child (0 – 16 years) NEW PATIENT QUESTIONNAIRE

To be completed by the Parent or Guardian
(Please print off and hand in to surgery with registration form)

Child Surname:	Forenames:
Address: Postcode:	Date of Birth:
	Gender *(please tick)* Male ☐ Female ☐

Details of Parents or Guardians

Mother's Name	Date of Birth	Telephone numbers Home Work Mobile:
Father's Name	Date of Birth	Telephone numbers Home Work Mobile:

Ethnic Origin (please tick)

White British ☐ Black British ☐ White Other ☐ Black Other ☐

Indian ☐ Pakistani ☐ Chinese ☐ Polish ☐

Other Ethic Group please specify _____

Disabilities

Does the child have any disabilities? YES ☐ NO ☐ If yes, please explain

Allergies

Does the child have any allergies or is sensitive to anything? YES ☐ NO ☐

If yes, what are they?

Please turn over /….

Child's Previous Health: please note any serious illnesses or hospital admissions

Year	Illness/Operation	Hospital

Repeat Medication

Is the child on any repeat medication? YES ☐ NO ☐

If they are on any repeat medication please make an appointment with the doctor and bring their medication with you to the appointment

Family History

Have any close relatives of the child (grandparents, parents, brothers, sisters) had any of the following? Please tick all that apply

Stroke ☐ Heart Attack ☐ Ischaemic Heart Disease ☐

Diabetes ☐ Thyroid Disorder ☐ Osteoporosis ☐

Breast Cancer ☐ Bowel Cancer ☐ Bronchus Cancer ☐

Stomach Cancer ☐ Ovarian Cancer ☐

Any other significant illness – please specify _____