



New Patient Questionnaire

JUNIOR REGISTRATION (UP TO 16 YEARS OLD)

Date of Registration

Have there been any health problems **YES NO** If yes, please give details.

Are both parents, brothers and sisters fit and well? **YES NO** If no, please give details.

SECTION RELATING TO PARENT OR GUARDIAN

Surname			
First Names			
Address			
	Postcode		
<small>Please supply us with this information, it is very important, even if you are ex-directory. We also need to have your phone number to enable you to use the automated booking system.</small>	Home Tel	Work Tel:	
	Mobile:		
Email			

Child's Surname	
Child's First Names	
Address (if different from above)	
Date of Birth	

Names and ages of brothers and sisters.

<u>Immunisation</u>	<u>TICK if received</u>	<u>Date</u>	<u>Place</u>	<u>TICK if GP</u>
1st Dip/Tet/Pertussis/Polio/Hib				
2nd Dip/Tet/Pertussis/Polio/Hib				
3rd Dip/Tet/Pertussis/Polio/Hib				
1st Meningitis C				
2nd Meningitis C				
3rd Meningitis C				
OR single Meningitis C				
1st MMR				
Pre-school booster Dip/Tet/Polio/ & 2nd MMR				

We need to ask about your ethnicity. Please tick one of the boxes and enter first language below.

- | | | | |
|--------------------------|--------------------------|------------------------------|--------------------------|
| British or Mixed British | <input type="checkbox"/> | Caribbean or Mixed Caribbean | <input type="checkbox"/> |
| African or Mixed African | <input type="checkbox"/> | Indian or Mixed Indian | <input type="checkbox"/> |
| Asian or Mixed Asian | <input type="checkbox"/> | Other | <input type="checkbox"/> |

Main language spoken

Any additional information?