Waterfoot
Medical Practice

New Patient Registration Questionnaire – Child Under 16

Please complete all information – 1 form is required for each new patient.

Your Details		
Title	Mr / Mrs / Miss / Ms	
First Name	**Surname**	
Date of Birth		
Gender		
Address		
Home Telephone Number	**Mobile Telephone Number**	
Email		
Are you happy to be contacted via email and text?	Email Yes / No	Text Yes / No
Main Language Spoken		
Do you need an interpreter or any sign language assistance	Yes / No If yes please provide details:	
Do you have a Disability	Yes / No If yes please provide details:	
Please provide the name and location of the Pharmacy that you would like prescriptions to be sent to		

Carer Information	
Are you a carer, i.e. do you look after someone who couldn't manage without your help?	Yes / No

Ethnic Group (please tick which applies)				
White	**Asian**	**Black**	**Mixed**	**Other**
British	Bangladeshi	African	White / Asian	Arab
Irish	Chinese	Caribbean	White / African	
Other	Indian	Other	White / Caribbean	
	Pakistani		White / Other	
	Other			
Any Other (please state)				
I do not wish to disclose (please tick)				

Next of Kin / Emergency Contact Information		
Title	Mr / Mrs / Miss / Ms	
First Name		**Surname**
Relationship to you		
Their Address:		
Their Home Telephone Number		**Their Mobile Telephone Number**

Parent or Guardian Information Please give details of the child's legal parents or guardians – i.e. those who have parental responsibility for the child.
Full Name
Relationship to the child
Address:

Home Telephone Number	**Mobile Telephone Number**	
E mail	**Registered at this practice?**	Yes / No
Full Name		
Relationship to the child		
Address:		
Home Telephone Number	**Mobile Telephone Number**	
E mail	**Registered at this practice?**	Yes / No

Medical Information		
Do you suffer or have suffered from any of the following: (Please tick all that apply)		
Asthma	Epilepsy	Alzheimer's or dementia
Cancer	Heart Disease	High blood pressure (hypertension)
Mental Health	Liver/Kidney Problems	Thyroid
Diabetes	Stroke	
Other (please give details)		
Do you / have you ever suffered from any allergies (please circle)	Yes / No If Yes, please provide details:	
Medication / Product / animal allergic to:	**Reaction i.e. rash / itch etc.**	

Smoking Status	
Do you smoke? *(Please circle)*	Yes / No / Ex-smoker
If 'Yes' or 'Ex-Smoker', how many do you or did you smoke per day?	
If 'Yes' are you interested in giving up smoking? (Please circle)	Yes / No

Current Medications

For Patients who regularly take prescribed medication: please provide further information about what medications you are currently taking including the name and the dosage if known.

For Women prescribed the oral contraceptive pill: we kindly request that you book an appointment for a pill check before your next prescription is due.

Patients Signature (for children over 13): _____

Signature of Parent(s) or Guardian(s): _____

Date: _____