Ratho Medical Practice

New Patient Questionnaire – Child

Name:	Date Of Birth:

Address: Home Telephone No: Mobile:

Next of kin :	Relationship:	Contact Details:

Have you ever been registered at Ratho Medical Practice before? If so, under what name were you registered & when?	Yes / No

Ethnicity – Please tick one box only.

White	Mixed	Asian or Asian British	Black or Black British	Other Ethnic Groups	Decline to provide Ethnic Group
☐	☐	☐	☐	☐	☐

MEDICAL BACKGROUND

ALLERGIES - Do you have any allergies? If YES please list below:

Drug Related Allergies:	
Non-Drug Related Allergies:	

Are you taking any medication? Yes / No (please circle)

(If you have a repeat prescription slip from your previous Practice please attach)

Health History:

Please list any serious illness, operations or conditions:

Immunisation History

Immunisation	Approximate Date Given

Thank you for your assistance in completing this Questionnaire.
Please hand it back with your Registration Form. If you are taking any regular prescribed medication you will require a GP consultation.