**Ratho Medical Practice**

**New Patient Questionnaire – Child**

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| --- | --- |
| **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** |

**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** |
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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.