FIRECLAY HEALTH
Your Health is Our Concern

New Patient Questionnaire for CHILDREN aged 0-15

Today's date: ....

MALE ☐ FEMALE ☐	Surname:
Date of Birth:	First name(s):

Home Address:	Home Tel:
	Contact Mobile no:
Postcode:	Contact Email: *(in block capitals)*
Name of person with parental responsibility:	
Relationship to child:	

Child's first language:

If this is not English, do you require an interpreter? YES ☐ NO ☐

Ethnic Group

White British ☐ Irish ☐ Other ....
Black Caribbean ☐ African ☐ Other ....
Asian Indian ☐ Pakistani ☐ Chinese ☐ Other ....
Mixed White + Black Caribbean ☐ White + Black African ☐ Other ....

Medical Information

Current medical conditions
Current medication *(please give strength and dosage if possible)*
Please make an appointment before requesting medication. Electronic Prescribing Service available - see Reception to nominate a local pharmacy to receive your electronic scripts, or to update nomination which transfers with GP records
Allergies to medicines or foods

Family History

Any serious illness particularly, heart disease, stroke, high blood pressure, diabetes, inherited diseases