PATIENTS WISHING TO REGISTER WITH THE ARLINGTON ROAD MEDICAL PRACTICE

Surname		**Forename**		**Date of Birth**	/ /
Address				**Postcode**	
Home Telephone No.			**Mobile Telephone No**		
Work Telephone No.			**Occupation**		

Ethnic Origin – please tick as appropriate (based on new national population Census categories)				
White:	Mixed:	Asian:	Black:	Chinese ☐
British ☐	White & Black Caribbean ☐	Indian ☐	Caribbean ☐	
Irish ☐	White & Black African ☐	Pakistani ☐	African ☐	
Scottish ☐	White & Asian ☐	Bangladeshi ☐		
Welsh ☐				
European ☐				
Other, please state		I do not wish an ethnic background to be stated ☐		

Communication Needs – Language	
What is your child's first language? Please state	
What is your first language? Please state	
If you or your child's first language is not English, do you need an interpreter for any consultations? Please tick	Yes ☐ No ☐
Do you require any communications sent by the Practice to be in your first language? Please tick	Yes ☐ No ☐

Communication Needs – Hearing Impairment/Vision Impairment/Disability
If communicating with the Practice is difficult for either you or your child, due to a hearing or vision impairment or some form of disability, please tell us about it by completing the Communication Needs form that is included in your Registration Pack. Thank you.

Education (4-15 year olds only)	
Which school does your child attend? Please state	

Birth	
Was your child born by normal delivery? Please tick	Yes ☐ No ☐
If no, please give details. Eg. caesarean section, forceps delivery	

Medical History - Has your child had any serious illnesses in the past? For example, illnesses requiring hospitalisation or long term treatment? Please give details, with dates, if possible.

Date	Illness

Surgical History - Has your child had any operations? Please give details, with dates, if possible.	
Date	Surgery

Family History - Is there a history of any of the following illnesses in your near family? (Parents/Brothers/Sisters). If so, please give details.			
Allergy (including asthma, eczema, hayfever)	Yes ☐ No ☐	Details	
Heart Attacks/Strokes (under the age of 60)	Yes ☐ No ☐	Details	
Diabetes	Yes ☐ No ☐	Details	
Any other inherited conditions	Yes ☐ No ☐	Details	

Immunisation History	
FOR OUR RECORDS WE NEED TO KNOW THE EXACT DATES OF IMMUNISATIONS OF CHILDREN UNDER SIX YEARS OF AGE. IF YOU DO NOT HAVE A RECORD OF YOUR CHILD'S IMMUNISATIONS, PLEASE CONTACT YOUR PREVIOUS DOCTOR FOR DETAILS, BEFORE YOU ATTENDING FOR YOUR FIRST APPOINTMENT.	
Immunisation	**Date**
1st Triple/Hib Vaccine & Polio	
2nd Triple/Hib Vaccine & Polio	
3rd Triple/Hib Vaccine & Polio	
Measles/Mumps/Rubella	
and/or Measles	
Pre-school Booster	
DID YOUR CHILD DEFINITELY HAVE THE WHOOPING COUGH (PERTUSSIS) VACCINE?	Yes ☐ No ☐
Has your child had any other immunisations such as Travel Immunisations? If yes, please give details below.	Yes ☐ No ☐
Immunisation	**Date**

Medication – Is your child taking any regular medication?			Yes ☐ No ☐
If yes, please give the details below…			
Name of Drug	Dose	Frequency/Day	Reason for taking it

Allergies – Is your child allergic to any medications, tablets or injections?	Yes ☐ No ☐
If yes, please give the details below…	
Name of Drug	Type of reaction that occurred

Lifestyle - If there are any factors in your family's circumstances, your housing or at home that you think might have a bearing on your child's health, please let us know.

Is your child a Member of a Military Family? If yes, please give relationship of service personnel to child.			
Service Personnel Surname		**Service Personnel Forename**	
Service Personnel DOB	D D M M Y Y Y Y		
Which Force do they serve in?	Air Force ☐	Army ☐	Navy ☐ Marines ☐
Service Number		**Regiment/Corp**	

Updated March 2023