CEDAR BROOK PRACTICE

CHILDREN'S NEW PATIENT QUESTIONNAIRE

Please complete this form for each child between the ages of **0 – 10 years**.

Important- children under 6 years old please provide a copy of vaccinations given- from red book

Name and address of a pharmacy to which electronic prescriptions can be sent:-

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Child's Surname: ……

Forename: …… DOB: ……

Address: ……

Telephone Number: …….. Mobile: ……

Mother's Name: …… DOB: …… Registered with us: Yes/No

Father's Name: …… DOB: …… Registered with us: Yes/No

MEDICAL HISTORY

Please list any **illnesses and dates**:
……

Please list any **operations and dates**: ……

Please list any **allergies**: ……..

Is child on any tablets, inhalers or other treatment? If yes, please **make an appointment with a GP before their medication runs out** (please bring medication or prescription slip to the appointment).

Ethnic Origin: (please circle)

White (British/English/Irish/Other), Mixed (White and Black Caribbean / White and Black African / White and Asian/Other), Asian or Asian British (Indian / Pakistani / Bangladeshi / Other Asian), Black or Black British (Black Caribbean / Black African / Other Black), Other Ethnic (Chinese / Other Ethnic Group) or Not Stated.