CRAMOND MEDICAL PRACTICE

NEW PATIENT QUESTIONNAIRE – UNDER 6 YEARS OLD

NAME: _____ DATE OF BIRTH: _____

PLACE OF BIRTH: _____ MALE/FEMALE: _____

ADDRESS: _____

POSTCODE: _____ TEL NO: _____

NEXT OF KIN (Name): _____ (Relationship): _____

Have you been registered here before? Yes / No

PERSONAL MEDICAL HISTORY
(please give dates where possible)

ILLNESSES _____

_____

_____

OPERATIONS _____

_____

_____

ACCIDENTS _____

_____

_____

ARE YOU TAKING ANY MEDICATIONS AT PRESENT? (please include diagnosis if known) _____

_____

_____

ALLERGIES _____

_____

_____

IMMUNISATION HISTORY- enter immunisation details below

	Date Given
1st DTP/POL/HIB	
2nd DTP/POL/HIB	
3rd DTP/POL/HIB	
1st Rotavirus	
2nd Rotavirus	
1st PCV	
2nd PCV	
3rd PCV	
1st Men B	
2nd Men B	
3rd Men B	
1st Men C	
2nd Men C (if applicable)	
3rd Men C (if applicable)	
Other PCV (if applicable)	
HIB/Men C	
MMR	
Booster DTP/POL/HIB (delete as appropriate)	
Booster MMR	
BCG	
Other: (state course)	
Other: (state course)	
Other: (state course)	

Please indicate your ethnic group

- ☐ White Scottish
- ☐ White British
- ☐ White Irish

Other White background (please state)

_____

- ☐ Asian - Indian
- ☐ Asian - Pakistani
- ☐ Asian - Bangladeshi
- ☐ Chinese

Other Asian background (please state)

_____

- ☐ Black Caribbean
- ☐ Black African

Other Black background (please state)

_____

- ☐ Mixed Race

Any other ethnic group (please state)

_____