Do you have any special communication needs? ☐ Yes ☐ No

If yes: ☐ Sign Language ☐ Large Print ☐ Other ……..

CONFIDENTIAL MEDICAL REGISTRATION FORM (CHILDREN UNDER 16)

Please complete all pages in FULL using BLOCK capitals

Surname

First Names (in full)

Previous Surnames

Title: ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Male ☐ Female

Date of Birth (day/month/year) NHS Number (if known) ☐☐☐ ☐☐☐ ☐☐☐☐

Town & country of Birth

Address

Post Code:

Telephone number: Mobile number:

Email address:

Please help us trace your previous medical records by providing the following information:

Your previous address in UK

Post Code:

Name of previous Doctor while at that address

Address of previous Doctor

Post Code:

If you are from abroad:

Your first UK address where Registered with a GP

Post Code:

If previously resident in UK date of leaving

Date you first came to UK

If registering a child under 5:

☐ I wish the child above to be registered with Park & St Francis Surgeryfor Child Health Surveliance

Personal Medical History…..

Type of Birth:
(eg normal, forceps, Caesarean If under 5)

Birth Weight:
(If under 5)

Feeding:
(Breast or bottlefed If under 5)

Has your child ever suffered from any important medical illness, operation or admission to hospital? If so please enter details below:

Condition	**Year diagnosed**	**Ongoing**
		Yes/No
		Yes/No
		Yes/No

Family History…..

Have any close relatives (*father, mother, sister, brother only*) ever suffered from: (please indicate who in the boxes)

Heart attack	Stroke	Diabetes	High blood pressure	Asthma	Glaucoma	Cancer

Immunisations ……

Please provide details of your childs immunisations with dates if possible (under 5's). If possible pelase give your Red Book to Reception to photocopy:

Immunsation	**Date**	**Immunisation**	**Date**
Tetanus		Booster: Tetanus	
Whooping Cough		Booster: Diphtheria	
Polio		Booster: Polio	
HiB		Booster: MMR	
Measles			
MMR			
BCG (TB)			
Meningitis			

List of current medication ……

Name of medication	Dosage

Allergies ……

Please list any allergies you have to any drugs/medication:

Name of medication	What was the problem or upset?

Ethnicity ……

☐ British or mixed British ☐ Irish ☐ African ☐ Caribbean ☐ Indian ☐ Pakistani
☐ Bangladeshi ☐ Chinese ☐ Other (please state): _____
☐ Decline to state

First Spoken Language: ……

Next of kin ……

Name: _____ Tel. contact number: _____

Relationship: _____

Signature ……

I acknowledge that it is my responsibility to let the practice know of any changes to my address, email and phone numbers

I confirm that the information that has been provided is true to the best of my knowledge.

Signed: _____ Date: _____

Signature on behalf of patient ☐ Signature of patient ☐

03/02/16