●●● The Garden Surgery

Children
New Patient Questionnaire

First Name(s) …… Surname(s) ……

Date of Birth: …… Place of Birth: ……

Address: ……

Post code: …… Gender: M/F ……..

Tel No: …….. Email: ……

Language: ……

ETHNIC ORIGIN *(please tick one)*

☐ White British
☐ White Irish
☐ White: any other background
☐ Mixed: white & black Caribbean
☐ Mixed: white & black African
☐ Mixed: white & Asian
☐ Mixed: any other mixed background
☐ Asian or Asian British: Indian
☐ Asian or Asian British: Pakistani
☐ Asian or Asian British: Bangladeshi
☐ Asian or Asian British: any other Asian background
☐ Black or black British: Caribbean
☐ Black or black British: African
☐ Black or black British: any other black background
☐ Chinese
☐ Any other ethnic group
☐ I do not wish to answer this question

(We are asking about your ethnic background so we can provide the best clinical care. There are some conditions that are more common in certain ethnic groups. Thank you for your cooperation

FAMILY MEDICAL HISTORY
Has any close first degree relative of yours suffered from any of the following?

Epilepsy	Yes/No	High Blood Pressure	Yes/No
Glaucoma	Yes/No	Cancer	Yes/No
Diabetes	Yes/No	Heart Attack or Angina	Yes/No
Strokes	Yes/No	Asthma	Yes/No

Please give more details:

……

MEDICINES

Are you taking any drugs or medicines? Yes/No

Please tell us the names and dose and how often you take the medicines.

……

ALLERGIES

Are you allergic to any medicines? Yes/No

Which Ones? …… What happens if you take them? ……

RELATIONSHIP

Name, address, and telephone No.

Mum:
……

DAD:
……

Siblings:
……

……

Patient Registration

It is a condition of your registration that you attend a New Patient Check. A brief history of your health will be recorded to inform the Healthcare Professionals of any treatment or care that you require. If you do not attend this appointment your registration will not be completed.

Have you registered with us because of a leaflet being delivered to you?

YES OR NO

Why have you chosen to register with this Practice?
(This answer is optional but will help us to understand why Patients register here)

All patients can expect their personal information, whether held on computer or paper, not to be disclosed without their consent

Signature of acceptance of Practice policies and standards as also advised in the Patient leaflet.

Name: .....

Signature .....

Date: .....