

The Park Surgery

NEW PATIENT QUESTIONNAIRE FOR CHILDREN UNDER 16

PLEASE COMPLETE THIS FORM AND RETURN IT TO THE RECEPTIONIST WITH YOUR REGISTRATION DOCUMENTS. THIS IS ALL REQUIRED FOR ACCEPTANCE ONTO THE GP LIST. THANK YOU.

Name.....

Date of Birth.....

Town & Country of Birth

Address.....

.....

Telephone Number.....

Mother's Name.

Ethnic Origin e.g. White British/Asian/Afro-Caribbean etc...please write in

.....

First Language e.g. English/Mandarin please write in

.....

Do you smoke: - Yes/No

Number per day.....

Do you drink alcohol: - Yes/No

How many alcoholic drinks do you have per week

.....

Summary Care Record. Please indicate your wishes Yes No

The content of the database includes the following: Drugs which you has been prescribed, Known adverse reactions to drugs & Known allergies . Only NHS staff