Charlton House Medical Centre
PRIVATE & CONFIDENTIAL

New Patient Registration Form - CHILD

PATIENT DETAILS

SURNAME:..... FIRSTNAME:.....

DATE OF BIRTH:..... SEX: (Please circle) MALE / FEMALE

ADDRESS:.....

POSTCODE:..... NHS Number:.....

NEXT OF KIN:..... HOME PHONE No:.....

WORK PHONE No:..... MOBILE:.....

PREVIOUS ADDRESS:.....

COUNTRY OF BIRTH:..... LANGUAGE SPOKEN:.....

PREVIOUS GP NAME:.....

PREVIOUS PRACTICE NAME/ADDRESS:.....

NAME OF CHILD'S SCHOOL:.....

ETHNICITY *(Please tick ☑ a box)*

White British		Asian/Asian-British-Indian	
White Irish		Asian/Asian-British-Pakistani	
Greek Cypriot		Asian/Asian-British-Bangladeshi	
Turkish Cypriot		Asian/Asian-British-East African	
Kurdish		Asian/Asian-British-Other	
Turkish		Black/Black British-Caribbean	
White Other		Black/Black British-African	
Mixed White & Black Caribbean		Black/Black British-Other	
Mixed White & Black African		Chinese	
Mixed White & Asian		Any other ethnic group	
Mixed Other		I decline to give my ethnicity	

PATIENT STATS

Approx Height: ..... Approx Weight: .....

MEDICAL HISTORY

Drug allergies(Please state): .....

Other allergies - Food/Animal/Other(Please State): .....

Any serious Illness/Operations(Please State): .....

Disability? (Please circle): YES NO

Please list any current medication you are taking: .....
.....

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IMMUNISATION STATUS(Has your child had the following immunisations)

Primary Immunisations

1st	YES / NO	DATE: .....
2nd	YES / NO	DATE: .....
3rd	YES / NO	DATE: .....

1 Year Old MMR

1st	YES / NO	DATE: .....
2nd	YES / NO	DATE: .....

Pre-School Booster

1st	YES / NO	DATE: .....

School Leaver Booster

1st	YES / NO	DATE: .....

Other Immunisations

		DATE: .....
		DATE: .....
		DATE: .....
		DATE: .....
		DATE: .....
		DATE: .....

FAMILY HISTORY(Please enter which member of the child's family has which condition, i.e. mother, father, sister, brother)

Asthma:	CVA/TIA/Stroke:	Thyroid Disease: .....
CHD:	Cancer:	Diabetes: .....
Epilepsy:	Hypertension:	Other: .....