MOREDON MEDICAL CENTRE

NEW REGISTRATION MEDICAL – **(Child under 16 years old)** **Confidential**

SURNAME: ..... FIRST NAMES: .....

DOB: ..... NHS NO: ..... PREVIOUS NAMES: .....

TELEPHONE NUMBERS: Home: ..... Mobile: .....

ADDRESS: .....

PREVIOUS ADDRESS: .....

PREVIOUS DOCTOR: ..... NAME OF SURGERY: .....

PREVIOUS HEALTH VISITOR AND ADDRESS OF CLINIC: .....

.....

CURRENT SCHOOL ATTENDED AND ADDRESS: .....

.....

PREVIOUS SCHOOL ATTENDED AND ADDRESS: .....

.....

ETHNIC GROUP (Please Tick)	
British	
Irish	
Other White	
White British Caribbean	
White British African	
White Asian	
Other Mixed	
Indian British	
Pakistani British	
Bangladeshi British	
Other Asian	
Caribbean	
African	
Other Black	
Chinese	

MAIN LANGUAGE	
(Please Tick)	
English	
Arabic	
Bengali	
Cantonese	
Gujarati	
Hindi	
Mandarin	
Polish	
Portuguese	
Punjabi	
Urdu	
World Languages (please state)	

DISABILITY	
(Please Tick)	
Registered Blind	
Partially Sighted	
Deafness	
Uses Wheelchair	
Uses Zimmer Frame	
Stick Only For Walking	

If aged 14 years or over - do you smoke? ***YES/NO*** If yes how many? …….. per day
If you are a smoker and would like help in giving up please ask to see our smoking cessation advisor.

Height ..... Weight ……..

Does your child suffer from any medical conditions e.g. asthma, eczema, hay fever, epilepsy etc.

CONDITION DATE

Has your child had any operations? OPERATION DATE

Does your child have any relatives that have or have had any serious illnesses e.g. heart disease/stroke, cancer, diabetes etc. RELATIVE DISEASE

MEDICATION - Does your child take any prescribed medication? Please list below.

NAME OF TABLET	STRENGTH	AMOUNT TAKEN	HOW OFTEN

Does your child take any medication or drugs that are not prescribed (over the counter)? Please list.

Please list any allergies to – FOOD MEDICATION

Does your child eat a normal diet YES/NO If no please give further details below

Please bring your child's Personal Health Record (red book) when registering.

VACCINATIONS	*DATE (IF KNOWN)*	*GIVEN BY GP/NURSE*	*GIVEN BY HEALTH CLINIC*
1st Stage (2 Months)			
2nd Stage (3 Months)			
3rd Stage (4 Months)			
HIB + MEN C Bstr			
MMR (12-15 Months)			
Meningitis C			
Pre-School Booster (4-5 Years)			
Whooping Cough			
Other			

Mother's full name and address

……

……

……Post code……

Telephone number ……

Father's full name and address

……

……

……Post code……

Telephone number ……

Signed …… Relationship to child …… Date ……

IF YOUR CHILD CHANGES THEIR NAME, ADDRESS OR TELEPHONE NUMBER PLEASE INFORM THE SURGERY AS SOON AS POSSIBLE