EVERGREEN OAK AND CREEKMOOR SURGERIES

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1 Borley Road, Creekmoor, Poole BH17 7DT
Tel: 01202 659351 Fax: 01202 603115

NEW PATIENT QUESTIONNAIRE - CHILDREN

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 (DD/MMM/YY) NHS Number

Town & Country of Birth

Address

Postcode:

Telephone Number Mobile Number

Email Address

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

Previous Address in UK

Postcode:

Name of Previous Doctor

Address of Previous Doctor

Postcode:

Are you arriving/returning from abroad:

Your first UK address where registered with a GP

Postcode:

If previously resident in the UK, what is your date of leaving?

What date did you come to live in the UK?

Ethnicity and First Language Details:

Please indicate you ethnic origin:

British or mixed British	☐	Carribean	☐	Bangladeshi	☐	
American	☐	Indian	☐	Chinese	☐	
African	☐	Irish	☐	Other (please state)	☐	
Asian	☐	Pakistani	☐	Decline to state	☐	

Please indicate your first language:

English	☐	Italian	☐	Russian	☐	Other (please state)	☐
French	☐	Polish	☐	Arabic	☐		
German	☐	Greek	☐	Hindi	☐	Decline to state	☐
Spanish	☐	Dutch	☐	Japanese	☐		

If you are registering a child under the age of 5:

I wish my child above to be registered at Evergreen Oak & Creekmoor Surgeries for Child Health Surveillance

Yes ☐ No ☐

Personal Medical History:

Has your child suffered from any important medical illness, operation or emergency admission to hospital?

Condition	Date/Year	Ongoing
		Yes / No
		Yes / No

Family Medical History:

Have any close relatives *(father, mother, sister, brother only)* ever suffered from any of the following: Please tick

Heart Attack	Stroke	Diabetes	High BP	Asthma	Glaucoma	Cancer
☐	☐	☐	☐	☐	☐	☐

Immunisation:

Is your child fully immunised? Yes ☐ No ☐ Don't know ☐

Has your child had two doses of the MMR (Measles, Mumps & Rubella) vaccine? Yes ☐ No ☐

Medication:

If you have a copy of your repeat medications, please list below or pass a copy to Reception staff with this form.

Medication	Dosage	Medication	Dosage

Prescription requests must be made in writing. We do not accept requests over the phone. You can add your child(ren) to your own SystmOnline Account and order medication, book and cancel appointments 24/7 using a SystmOnline Account. Sign up form is at the front of this registration.

In order to save YOU, the patient, time, you can use the Electronic Prescribing Service (EPS) which allows your scripts to be sent electronically to a nominated pharmacy. Please nominate a pharmacy below:

Allergies and Sensitivities:

Please list any allergies or sensitivites your child may have:

Signature

I confirm the information I have provided is true to the best of my knowledge.

Signature _____ Date _____

Signature of parent ☐ Name of parent _____

For administrative use only

Form checked and coded ☐ Form scanned ☐