

EVERGREEN OAK AND CREEKMOOR SURGERIES

43 Commercial Road, Parkstone, Poole BH14 0HU
Tel: 01202 747496
Email: evergreen.reception@dorset.nhs.uk
Website: www.evergreenoaksurgery.co.uk

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



NEW PATIENT QUESTIONNAIRE - CHILDREN

Please complete all pages in FULL using BLOCK capitals

Surname	<input type="text"/>	
First Names (in full)	<input type="text"/>	
Previous Surnames	<input type="text"/>	
Title	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/>
Date of Birth (DD/MM/YY)	<input type="text"/>	NHS Number <input type="text"/>
Town & Country of Birth	<input type="text"/>	
Address	<input type="text"/>	
	Postcode: <input type="text"/>	
Telephone Number	<input type="text"/>	Mobile Number <input type="text"/>
Email Address	<input type="text"/>	

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

Previous Address in UK	<input type="text"/>	
	Postcode: <input type="text"/>	
Name of Previous Doctor	<input type="text"/>	
Address of Previous Doctor	<input type="text"/>	
	Postcode: <input type="text"/>	

Are you arriving/returning from abroad:

Your first UK address where registered with a GP	<input type="text"/>	
	Postcode: <input type="text"/>	
If previously resident in the UK, what is your date of leaving?	<input type="text"/>	
What date did you come to live in the UK?	<input type="text"/>	

Ethnicity and First Language Details:

Please indicate your ethnic origin:

British or mixed British	<input type="checkbox"/>	Caribbean	<input type="checkbox"/>	Bangladeshi	<input type="checkbox"/>
American	<input type="checkbox"/>	Indian	<input type="checkbox"/>	Chinese	<input type="checkbox"/>
African	<input type="checkbox"/>	Irish	<input type="checkbox"/>	Other (please state)	<input type="checkbox"/>
Asian	<input type="checkbox"/>	Pakistani	<input type="checkbox"/>	Decline to state	<input type="checkbox"/>

Please indicate your first language:

English	<input type="checkbox"/>	Italian	<input type="checkbox"/>	Russian	<input type="checkbox"/>	Other (please state)	<input type="checkbox"/>	<input type="text"/>
French	<input type="checkbox"/>	Polish	<input type="checkbox"/>	Arabic	<input type="checkbox"/>			
German	<input type="checkbox"/>	Greek	<input type="checkbox"/>	Hindi	<input type="checkbox"/>	Decline to state	<input type="checkbox"/>	<input type="checkbox"/>
Spanish	<input type="checkbox"/>	Dutch	<input type="checkbox"/>	Japanese	<input type="checkbox"/>			

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
<input type="text"/>	<input type="text"/>	Yes / No
<input type="text"/>	<input type="text"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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 sensitivities 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

Registered Form checked and coded Form scanned