

DR G LEWIS, DR D L JONES & DR G M RHYS

NEW PATIENT QUESTIONNAIRE FOR UNDER 5s

Bishops Road Medical Centre
1 Bishops Road
Whitchurch
Cardiff, CF14 1LT
Tel: 029 20522355/522455
Fax: 029 20522686

Tongwynlais Surgery
1 St Michaels Close
Tongwynlais
CF15 7LB
Tel: 029 20810311

Thank you for registering your child/guardian at this practice. **The registration forms should be returned to the practice as soon as possible. It is important that your child(s)/guardian(s) details are entered onto our computer system before their first visit.** Information about the practice and the services we offer can be obtained from the practice leaflet.

Is Your Child from Overseas? Or a British National returning to the UK following emigration? Are you planning to stay in the UK for longer than 6 months?

Before your child/guardian is accepted as a patient at this practice you will need to provide us with evidence of duration of stay in this country, eg, PASSPORT, EHIC card and any other relevant documentation confirming duration of stay and residency. Copies of these documents will be photocopied and returned to you. The application will then be verified using Department of Health Guidelines and we will inform you of our decision in writing. This process should only take a few days.

Please fill in the details below as accurately as possible.

SURNAME:	FORENAMES:
D.O.B:	MOTHERS NAME:
ADDRESS:	TELEPHONE NO:
POSTCODE:	
PLACE OF BIRTH:	HOUSING: Eg, house, flat, mobile home, maisonette, other
PREVIOUS GPs NAME	PREVIOUS GPs ADDRESS:

ETHNICITY:

- | | | | | | |
|---------------|--------------------------|-------------------|--------------------------|-------------|--------------------------|
| British | <input type="checkbox"/> | White & Asian | <input type="checkbox"/> | Other Asian | <input type="checkbox"/> |
| Irish | <input type="checkbox"/> | Other mixed | <input type="checkbox"/> | Caribbean | <input type="checkbox"/> |
| Other white | <input type="checkbox"/> | Indian/British | <input type="checkbox"/> | African | <input type="checkbox"/> |
| W&B Caribbean | <input type="checkbox"/> | Pakistan/British | <input type="checkbox"/> | Other black | <input type="checkbox"/> |
| W&B African | <input type="checkbox"/> | Bang/British Bang | <input type="checkbox"/> | Chinese | <input type="checkbox"/> |

NEXT OF KIN – Optional – We have the facility to record the name and contact details of a Relative or friend that may be contacted in an emergency

NAME:	ADDRESS:	RELATIONSHIP:
		Contact Tel No:

PERSONAL MEDICAL HISTORY – Please list any medical conditions that require the issue of regular repeat prescriptions

IMPORTANT – YOUR CHILD WILL NEED TO SEE THE DOCTOR BEFORE THEIR CURRENT MEDICATION SUPPLY RUNS OUT

FAMILY MEDICAL HISTORY – have any of the childs immediate family suffered any of the following conditions?

DIABETES	YES	NO	WHO?
HEART DISEASE	YES	NO	WHO? Under 60 - Over 60 -
HIGH BLOOD PRESSURE	YES	NO	WHO?
EPILEPSY	YES	NO	WHO?
STROKE	YES	NO	WHO?
CANCER	YES	NO	WHO? WHAT TYPE?
ASTHMA	YES	NO	WHO?

Has your child any allergies? Eg nuts, penicillin etc If yes please give details:

Does your child need any specific requirements if attending the Surgery?
Eg, disabled access/ramp, interpreter etc. If yes please give details:

Are your childs necessary vaccinations up to date?

We only share this information with other healthcare bodies and it will not be used for any other purpose without the consent of the Parent/Guardian of the child concerned.

Parent/Guardians Signature: DATE: