NEW PATIENT FORM – CHILD (under 14 years) **PETERCULTER MEDICAL PRACTICE**

CORONATION ROAD
PETERCULTER
ABERDEEN
AB14 0RP
Tel. No. 01224 733535

Welcome to our Practice!

To enable us to provide your child with appropriate healthcare, we would be grateful if you could complete the following questionnaire along with your child or on his/her behalf. If your child is on regular medication and/or has any medical condition which requires regular review, please make an appointment for him/her to see a doctor to discuss this.

Drs Harris, Owen, Howarth, McMain, Sudder and Ede

PERSONAL DETAILS

Name ..... Date of Birth .....

Address ..... Nationality .....

..... Marital Status .....

..... Parent's Occupation:

Tel. No.: School ..... Mother: ..... Father: .....

Signature (Parent/Guardian) ..... Date .....

Which Ethnic Group do you belong to? You are not obliged to complete this section

☐ White ☐ Chinese ☐ Indian ☐ Bangladeshi ☐ Pakistani ☐ Black-African ☐ Black-Caribbean

☐ Other (Please State) ……. ☐ I do not wish to give this information

Smoking Habits (for over 14 years only)

Smoker ☐ Number of cirgarettes/cigars per day _____ Non-Smoker ☐

Do you drink alcohol regularly? **YES** **NO** (Please Circle)

Do you exercise regularly? **YES** **NO** (Please Circle)

If **YES** what do you do? How Often? .....

Childhood Immunisations: When (year) did your child have any of the following immunisations

	YEAR		**YEAR**
Primary Immunisations HIB/DTP/MEN C/POLIO		CHOLERA	
MMR		TYPHOID	
MMR BOOSTER		HEPATITIS A	
Pre-School Booster (DIP/TET/POLIO)		HEPATITIS B	
HIB		MEASLES/RUBELLA (MR)	
RUBELLA		OTHER*	
*Please give details			

Do you have a family history (Mother, Father, Brother, Sister) of:

	(Please circle)		Elaborate (Mother, Father, etc, giving age when diagnosed)
Cancer	**YES**	**NO**	
Heart Disease	**YES**	**NO**	
Stroke	**YES**	**NO**	
Diabetes	**YES**	**NO**	
Asthma	**YES**	**NO**	
Epilepsy	**YES**	**NO**	

If your parents are still alive, are they in good health?

Mother	**YES**	**NO**	
Father	**YES**	**NO**	

If your parents are dead, at what age did they die and from what?

	AGE	**CAUSE OF DEATH** (if known)
Mother		
Father		

YOUR OWN MEDICAL DETAILS:

Do you personally suffer from:	(Please circle)		Elaborate
Allergies	**YES**	**NO**	
Asthma	**YES**	**NO**	
Diabetes	**YES**	**NO**	
Heart Disease	**YES**	**NO**	
Raised Blood Pressure	**YES**	**NO**	
Epilepsy	**YES**	**NO**	
Under/Overactive Thyroid	**YES**	**NO**	
Cancer	**YES**	**NO**	
Mental Health problems, e.g. depression	**YES**	**NO**	
Any other medical conditions	**YES**	**NO**	

Previous medical history: Operations, hospital admissions, major illnesses. (Please give dates)

List any medication you are currently taking:
(Prescribed and/or over the counter)

Are you taking any supplements (eg iron, vitamins, calcium etc)

Did you have a Flu Vaccination in the preceding 1 September to 31 March? **YES** **NO** Please enter date

Do you have a Carer? YES/NO Name Relationship

Are you a Carer? YES/NO If **Yes** a) Relationship of person you look after

b) Do you require Carer's Needs Assessment **YES/NO**