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| Riverside Surgery – New Patient QuestionnairePlease fill in a form for each child under 16 years of age |

**Date form filled:**

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| **Surname: Forenames:** **Date of birth: Male Female****Address: Post code:****Email: Tel No: Mobile no:****I am happy to receive text messages from the surgery Yes/No** |
| **Ethnic origin: White Black Caribbean Black African Indian****Pakistani Bangladeshi Chinese Other** **Main spoken language: English Urdu Other: please specify**  |

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| **Children between the Ages of 5 & 16:****Name of School:****Children of all ages – please list all significant past medical history.****Please be as specific as you can, particularly if your child suffers recurrent headaches.** **There is no need to list minor illness eg. Coughs and colds:** |

**Where possible please provide your child’s Birth Certificate as proof of ID.**

**If between the ages of 4 months and 5 years old please provide their Child Health Book (Red Book), so that we can photocopy their immunisation record.**