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

**Date form filled:**

|  |
| --- |
| **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** |

|  |
| --- |
| **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.**