OLD TOWN SURGERY CHILD UNDER 15
NEW PATIENT REGISTRATION/HEALTH QUESTIONNAIRE

Surname: …………………………………………………..

Forename(s): ………………………… Date of Birth: ………………

Address: …………………………………………………

…………………………… Post Code: …………………..

Tel: …………………………………………………………….
Do you have any family members registered at this practice?
Name: Relationship:

PAST MEDICAL HISTORY:
Please give details of any history of Chronic Diseases
Heart Disease? Yes/No
Stroke? Yes/No
Cancer? Yes/No Site of Cancer ………………………….
Diabetes? Yes/No
Asthma? Yes/No

ALLERGIES:
Are you allergic to anything? (Medication/Foods) Yes/No
If Yes, Please give details: ………………………………….
FAMILY HISTORY:
Is there a history of any of the following in your family before the age of 65?
Heart Disease:Yes/No Family Member: …………………
Stroke: Yes/No Family Member : ………………………
Cancer: Yes/ No Family Member: ………………………..
Site of Cancer: …………..........
Diabetes? Yes/ No
Asthma? Yes/No

MEDICATION:
Please give details of any Medication that you take regularly

………………………………………………………………………………………….