

NEW PATIENT QUESTIONNAIRE – CHILD

Name: _____ Date of Birth: ____ / ____ / ____

Address: _____

_____ Post Code: _____

Telephone No: _____ School: _____

Parent/Guardian: _____

Ethnic Origin: _____ **Ethnic Origin Declined (_____)**
Please ask at reception for list Please tick if you do not wish to state

Contact Details (if different): _____ Telephone: _____

Immunisations & Dates: _____

Allergies: _____

Previous Illnesses and/or Operations **(Including dates)** _____

Current Medication: _____
