The Health Care Complex

New Patient Questionnaire – Children U16

Personal Details	
Full Name	
Date of Birth	
Address	
Postcode	
Home Number	
Mobile Number	
Sex	
Ethnic Origin	
Main Language	

Consent for SMS Messaging and Online Services (Please circle)		
Consent for sending SMS messaging	Yes	No
Consent for using online services	Yes	No

Form of ID		
Birth Certificate presented and name verified	Yes	No

Next of Kin or Foster/Carer Details		
Full Name		Relationship to you
Address		Contact Number and other details
Full Name		Relationship to you
Address		Contact Number and other details

Medical History			
Do you suffer with any of the following:			
Angina		Epilepsy	
Diabetes		Heart Attack	
Cancer		Stroke	
COPD		Mental Illness	
Asthma		Hypertension	
Hypothyroidism		Visually Impaired	
Hearing Impaired		Learning Disabilities	

Family History – Have your parents, brothers or sisters had any of the following	
Diabetes	
Heart Attack/Angina	
Stroke	
Bowel Cancer	
Breast Cancer	
Ovarian Cancer	
Thrombosis	

Any Known Allergies?	
Yes	No
If yes, please indicate:	