**UNDER 16s NEW PATIENT FORM**

**MUST BRING RED IMMS BOOK OR LIST OF IMMUNISATIONS**

**Your contact details**

Title Mr O Miss O Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_\_\_ First Names\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

House Name/House Number \_\_\_\_\_\_\_ Home Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postcode\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Information about you**

What school are you at? ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your first language? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you need an interpreter? Yes O / No O

**Ethnic Group**

White British O Irish O Other O please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Black Caribbean O African O Other O Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Asian Indian O Pakistani O Chinese O

Other O Please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mixed White + Black Caribbean O White + Black African O White + Asian O

Other O please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Please tell us any communication needs you may have** |

**Religion**

Church of England O Christianity O Buddhism O Jehovah’s Witness O

Roman Catholic O Sikhism O Hinduism O Islam O

Other religion please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Previous GP**

**Name and Address of Previous GP**

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**Please list the strength, dose and daily amount of any medicines being taken:**

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**Allergies**

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**Smoking if Applicable**

Do you smoke? Yes O/No O

If so how many cigarettes do you smoke a day?

If ‘No’ have you ever smoked? Yes O/No O

If you are an ex-smoker, how many cigarettes or ounces of tobacco did you smoke per day?

**Family History**

Please state any serious illness, in particular cancer, heart disease, stroke, high blood pressure. Diabetes, or any inherited disease. Please state your relationship to the individual and in the case of cancer, the type of cancer.

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**Next of Kin**

Please give name, address and telephone number of next of kin.

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| --- |
| Name:  Contact Number:  Relationship:  Address: |