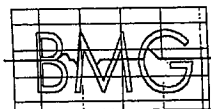


# **THE BARNARD MEDICAL GROUP**

## **NEW PATIENT QUESTIONNAIRE FOR CHILDREN**

<b>PATIENT DETAILS</b>		
<b>First Name:</b>	<b>Surname:</b>	<b>Date of Birth:</b>
<b>Home Address:</b>		
<b>Male</b> <input type="checkbox"/> <b>Female</b> <input type="checkbox"/>	<b>Title:</b>	<b>Previous Surname:</b>
<b>Home Telephone:</b>		<b>Mobile:</b>
<b>Previous Address:</b>		
<b>Name and address of previous Doctors:</b>		
<b>Parents Names:</b>		
<b>School Address Details:</b>		



# **THE BARNARD MEDICAL GROUP** **NEW PATIENT QUESTIONNAIRE FOR CHILDREN**

ETHNICITY				
<u>White</u>	<u>Asian</u>	<u>Black/Black British</u>	<u>Other</u>	<u>Not Stated</u>
British <input type="checkbox"/>	Indian <input type="checkbox"/>	Caribbean <input type="checkbox"/>	Chinese <input type="checkbox"/>	Prefer not to answer <input type="checkbox"/>
Irish <input type="checkbox"/>	Pakistan <input type="checkbox"/>	African <input type="checkbox"/>	Other ethnic <input type="checkbox"/>	
Other <input type="checkbox"/>	Bangladeshi <input type="checkbox"/>	Other <input type="checkbox"/>		
First Language Spoken: English <input type="checkbox"/> Other <input type="checkbox"/> Please state:				
IMMUNISATIONS				
Two months old	Three months old	Four months old	12-13 months old	Pre-school boosters
Date:	Date:	Date:	Date:	Date:
ANY OTHER IMMUNISATIONS				
Please list any serious illnesses/ operations/ accidents/ disabilities (with dates):				

THANK YOU FOR COMPLETING YOUR NEW PATIENT QUESTIONNAIRE