THE BARNARD MEDICAL GROUP

NEW PATIENT QUESTIONNAIRE FOR CHILDREN

PATIENT DETAILS		
First Name:	**Surname:**	**Date of Birth:**
Home Address:		
Male ☐ **Female** ☐ **Title:**	**Previous Surname:**	
Home Telephone:	**Mobile:**	
Previous Address:		
Name and address of previous Doctors:		
Parents Names:		
School Address Details:		

PTO

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ETHNICITY

White	Asian	Black/Black British	Other	Not Stated
British ☐	Indian ☐	Caribbean ☐	Chinese ☐	Prefer not to answer ☐
Irish ☐	Pakistan ☐	African ☐	Other ethnic ☐	
Other ☐	Bangladeshi ☐	Other ☐		
	Other ☐			

First Language Spoken: **English** ☐ **Other** ☐ **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

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