**Logo, company name

Description automatically generated Drs Cook, Teff, Embling & Cuff**

The Surgery, Bissoe Road, Carnon Downs, Truro, TR3 6JD - Telephone: 01872 863221

**CHILD REGISTRATION QUESTIONNAIRE**

This questionnaire will be placed in your medical records and will remain confidential.

**PERSONAL DETAILS**

SURNAME…………………………………………………………………. PREVIOUS SURNAME……………………….......................................

FORENAMES…………………………………………………………….. DATE OF BIRTH……………………………………………………………………

HOME ADDRESS……………………………………………………………………………………………………………………………………..................

………..……………………………………………………………………… POST CODE…………………………………………………………………..……..

MOBILE…………………….………………………………………………..OPT IN OPT OUT

Tick here to OPT IN so that we can contact you via SMS for your patient care including health campaigns, nurse appointment reminders and news from the practice

E-MAIL ADDRESS………………………………………………………… OPT IN OPT OUT

Tick here to OPT IN so that we can contact you via email for your patient care including health campaigns, nurse appointment reminders and news from the practice

To register for online services (booking appointments etc) please ask reception for a separate leaflet.

MARITAL STATUS…………N/A …………………………… OCCUPATION…………………………………N/A …………………….

HOME TELEPHONE…………………………………………………………………

**PARENTAL RESPONSIBILITY**

MOTHER’S NAME………………………………………………………….…………PHONE CONTACT………………………………..…………………..

FATHER’S NAME…………………………………………………..…………………PHONE CONTACT………………………………………..…………..

OTHER (ie Grandparent/Guardian) …………………………………………..PHONE CONTACT…………………………………………………….

HOME TELEPHONE…………………………………………………………………

**PREVIOUS GP DETAILS**

NAME & ADDRESS…………………………………………………………………………………………………………………………………………………..

|  |  |  |  |
| --- | --- | --- | --- |
| CONDITION | YES | NO | DETAILS |
| Diabetes |  |  |  |
| Raised blood pressure |  |  |  |
| Blood disorders/anaemia |  |  |  |
| Heart disease/heart attack/angina |  |  |  |
| Asthma/hay fever/eczema |  |  |  |
| Lung disease/bronchitis/emphysema |  |  |  |
| Stroke/TIA |  |  |  |
| Skin disorders |  |  |  |
| Epilepsy/blackouts |  |  |  |
| Nervous disorders/depression |  |  |  |
| Thyroid condition |  |  |  |
| Bladder or kidney disorder |  |  |  |
| Stomach or bowel disorders |  |  |  |
| Hepatitis/jaundice |  |  |  |
| Cancer |  |  |  |
| Any operations |  |  |  |

**PLEASE COMPLETE THESE QUESTIONS GIVING BRIEF DETAILS WHEN YOU ANSWER YES**

Are you receiving any medicines, tablets or cream on a prescription? Please list them…………………………..........................

……………………………………………………………………………………………………………………………………………………………………………..

Do you have any allergies?..........................................................................................................................................

Are you currently under the care of a hospital specialist or awaiting admission to hospital? Give details…………………………

…………………………………………………………………………………………………………………………………………………………………………

**ETHNICITY**

The Department of Health are collecting this information to help the NHS and Social Services to understand the needs of patients and service users from different groups, identify risk factors, improve public health and comply with the law. The 16 ethnic groups used are standard categories and allow most people to identify themselves. If you need to complete the box labelled 'Other ethnic background', please give details so that we can better understand your needs.

If you do not wish to provide this, please tick the 'Information refused' box at the end of the list.

Please tick the description which you feel is most appropriate.

|  |  |  |  |
| --- | --- | --- | --- |
| White - British |  | Asian or Asian British - Bangladeshi |  |
| White - Irish |  | Other Asian background |  |
| Other - White background |  | Black or Black British - Carribean |  |
| Mixed - White and Black Carribean |  | Black or Black British - African |  |
| Mixed - White and Black African |  | Other Black background |  |
| Mixed - White and Asian |  | Chinese |  |
| Other mixed background |  | Other ethnic background |  |
| Asian or Asian British- Indian |  |  |  |
| Asian or Asian British - Pakistani |  | Information refused |  |

**Childhood Immunisations**

Please fill out this form as accurately as you can i.e with exact dates. If you do not have this information please contact your old surgery who will give you the number of the computerised child health dept for your previous area. This only applies if your child’s immunisations were given outside of Cornwall. If in Cornwall the number is 01872 254537.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Date (1) | Date (2) | Date (3) | Date | Date | Date |
| Diptheria |  |  |  |  |  |  |
| Tetanus |  |  |  |  |  |  |
| Pertussis |  |  |  |  |  |  |
| Polio |  |  |  |  |  |  |
| Hib |  |  |  |  |  |  |
| Prevenar |  |  |  |  |  |  |
| Men C |  |  |  |  |  |  |
| MMR |  |  |  |  |  |  |
| HPV |  |  |  |  |  |  |
| BCG |  |  |  |  |  |  |

Childs Name ………………………………………………………………………………..

DOB…………………………………………………………………………..