KELTY MEDICAL PRACTICE
NEW PATIENT REGISTRATION – CHILDREN

NAME …….....

ADDRESS …….....

DATE OF BIRTH …….....… PHONE NO. …….…....…

NEXT OF KIN (N.O.K) NAME .....

N.O.K RELATIONSHIP ..... N.O.K TEL. NO. .....

ETHNIC GROUP – please circle the most appropriate description:

White Scottish	White English	White Irish	White Northern Irish
White Welsh	White British	White Polish	White Gypsy/Traveller Other
WhitePakistani	Indian	Bangladeshi	Chinese
Other Asian	African	Caribbean	Black
Arab	Mixed ethnic groups	Other African/Caribbean/Black	
Other Ethnic Group		Do Not Wish to Respond	

HEALTH HISTORY
Please list any illnesses, operations or accidents and the year they occurred (if known):

…….....…

…….....…

MEDICATIONS

Name (and strength)	Dosage	How long taken?
…….....…		
…….....…		

ALLERGIES
Are you known to be allergic or had any upset to medicines? Yes / No

If so, please state the name of the medicine …….....

IMMUNISATIONS/VACCINATIONS		DATE DONE
*Diptheria, Tetanus, Pertussis, Polio, Hib and Men C (*delete as appropriate)	1st	…….....…
	2nd	…….....…...
	3rd	…….....…
MMR (measles, mumps & rubella)		…….....…
Pre-school booster (diptheria, tetanus, pertussis, polio & MMR)		…….....…
Rubella (German Measles only)		…….....…