FIRRHILL MEDICAL CENTRE

DR. BARBARA STEWART
DR. RICHARD COCKBURN
DR. ALASDAIR FORD
DR. HOLLY CAKEBREAD
DR SUSAN PEDDIE

165 COLINTON MAINS DRIVE
EDINBURGH EH13 9AF

TEL 0131 441 3119

UNDER 16 New Registration Form

We are pleased that you have applied to register your child with this practice. By providing the following information you will help us to understand his/her medical requirements as well as assisting us with the registration process. The information you give will be treated in the STRICTEST CONFIDENCE. Together with this sheet you should have been offered a *Practice Brochure* describing the services we offer, if not please request one. Please complete this form as fully as possible and return it to reception. Please note that your child is NOT registered with this practice until a doctor has agreed to take him/her onto the practice list.

DATE .....

NAME
FIRST (Christian) NAMES SURNAME/FAMILY NAME SEX MALE/ FEMALE

DATE OF BIRTH
DAY / MONTH / YEAR

NHS Number
(if known)

ADDRESS

_____

Post code **Tel Number**

Email address:

If you are aged 12-16 and you wish to use your parent's mobile number/email, please tick this box and we will contact you again when you turn 16	☐

SCHOOL

PRESENT _____

PREVIOUS _____

Who else lives at this address with your child?

Your Child's Previous Address: -

Name & Address of last GP

Next of Kin/Guardian:

Name _____

Relationship: Address

_____

Tel No.

PERSONAL HEALTH

Please list any serious illnesses, hospital admissions or operations your child has had

Year	Hospital	Nature of Illness/Operation

Please tick here if your child has no significant history or problems. ☐

Does your child have or has he/she had any of the following problems? (please circle)

Asthma Diabetes

Learning Difficulty

MEDICATION

Does your child take any medication regularly (please bring labelled containers), **if so, please list:**

PLEASE TICK HERE IF YOUR CHILD DOES NOT TAKE ANY REGULAR MEDICATION ☐

FAMILY MEDICAL HISTORY Please enter details of any major illnesses in family members: -

Your Child's Birth History: -

Place of Birth: - **Birth Weight: -**

Type of Delivery: please circle Normal Forceps Caesarean Section

Intensive Care after delivery Yes / No **Breast Fed** Yes / No **How long?**

Previous Immunisations **Please state how many and dates if possible**

Polio	Yes / No
Diphtheria	Yes / No
Tetanus	Yes / No
Pertussis (Whooping Cough)	Yes/ No
HIB	Yes / No
Meningococcal C	Yes / No
Pneumococcal	Yes / No
Measles	Yes / No
Mumps	Yes / No
Rubella	Yes / No
TB (Tuberculosis)	Yes / No
Hepatitis A	Yes / No
Hepatitis B	Yes / No

Does your child have any current health problems?

Ethnic

Please indicate your child's ethnic origin by ticking the box which most closely reflects his/her background –

White

Scottish ☐ .9S13. British ☐ .9S10. Irish ☐ .9S11. Other White background ☐ .9S12.

Asian, Asian Scottish or Asian British

Indian ☐ .9S6.. Pakistani ☐ .9S7.. Bangladeshi ☐ .9S8.. Other Asian background ☐ .9SH..

Black, Black Scottish or Black British

Caribbean ☐ .9S2.. African ☐ .9S3.. Other Black background ☐ .9SG..

Chinese ☐ .9S9..

Mixed

White & Black Caribbean ☐ .9SB5. White & Black African ☐ .9SB6. White & Asian ☐ .9SB2

Other Mixed background ☐ .9SB4.

Any other background ☐ .9SJ..

If you do not wish to state your child's ethnic background please tick this box ☐ .9SD.

Please state your preferred language …….

Will you require an interpreter when you consult the doctor or nurse ? Yes ☐ No ☐

Practice use only :

Weight ☐ Urinalysis (multistix) ☐

Height ☐