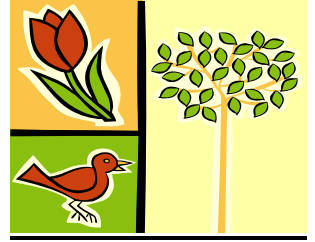
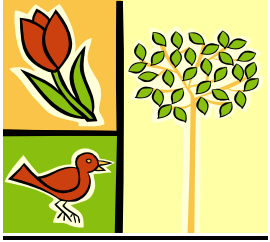


**NEW MILTON HEALTH CENTRE PRACTICE  
NEW PATIENT HEALTH QUESTIONNAIRE  
(Children 16 and under)**



**Name**.....

**DOB**.....

**Telephone No**.....

Has your child ever had any of the following:

	YES	NO
Operation If yes please give details below.	<input type="checkbox"/>	<input type="checkbox"/>

Any persistant illness or disease? If yes please give details below.	<input type="checkbox"/>	<input type="checkbox"/>
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Please list any regularly prescribes medication  
your child takes

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Does your family have a history of any serious illness? If yes please give details below.	<input type="checkbox"/>	<input type="checkbox"/>
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Does your child have any allergies? If yes please list below.	<input type="checkbox"/>	<input type="checkbox"/>
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Do you or your partner smoke? If yes your child is exposed and is therefore classed as passive smoker	<input type="checkbox"/>	<input type="checkbox"/>
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**Height** ..... **Weight** .....

**If you are willing please indicate your child's ethnicity – this is required as some origins are more prone to certain disease areas. If left blank we will consider as a refusal.**

White	<input type="checkbox"/>	Not willing to indicate	<input type="checkbox"/>
White & Black Caribbean	<input type="checkbox"/>	White & Black African	<input type="checkbox"/>
Other Mixed background	<input type="checkbox"/>	Black Caribbean	<input type="checkbox"/>
Other Black Background	<input type="checkbox"/>	Indian	<input type="checkbox"/>
Bangladeshi	<input type="checkbox"/>	Other Asian Background	<input type="checkbox"/>
Chinese	<input type="checkbox"/>	Other	<input type="checkbox"/>
		Pakistani	<input type="checkbox"/>
		Black African	<input type="checkbox"/>
		White & Asian	<input type="checkbox"/>

If you would like to have a talk with your new doctors please book a telephone consultation at reception when you hand in this form.

.....  
Signed

...../...../.....  
Date

For Office Use Only; Patient No.....	<input type="checkbox"/>	Date.....	Time.....
Passive Smoker	<input type="checkbox"/>	Height/Weight entered	<input type="checkbox"/>
Ethnicity data entered	<input type="checkbox"/>	Other data	<input type="checkbox"/>
Form processed by .....		Date.....	