Aboyne Medical Practice Registration Form

CHILD UNDER 5 YEARS OLD – PERSONAL DETAILS

DO YOU REQUIRE ASSISTANCE /INTERPRETER TO HELP YOU COMPLETE THIS FORM?
If "Yes" please make enquiries at reception.

SURNAME		DATE OF BIRTH	
FORENAMES		PLACE OF BIRTH	
ADDRESS			
	Postcode:		
If your address maybe difficult to find (even with sat nav) please give brief details.			
TEL:	Home:	Mobile:	Work:
Tick box if you DO NOT wish to be contacted by SMS or email	☐		
Next of Kin & Tel No.			

MEDICAL HISTORY

Has your child ever been in hospital for anything at all? (ie. Investigations/Operation)
If "Yes" please state when and for what.

Has your child ever had any medical illnesses or problems they have needed to see the doctor regularly for?
If "Yes" please give details, including dates where possible.

MEDICINES - Please list any medicines that your child uses regularly.

ALLERGIES - Is your child allergic to any medicines or any other substances? E.g. pollen, nuts, other foods.
If "Yes" please give details

FAMILY HISTORY – Does anyone in your child's family suffer from (presently or in the past)any of the following conditions?
Please tick and state how old they were at the time.

	Mother	Father	Aunt	Uncle	Grandmother	Grandfather	Brother	Sister
Heart Attack								
Diabetes								
Stroke								
Asthma								
High Blood Pressure								
Cancer								

ETHNIC GROUP

You are not obliged to complete this section. Please tick as appropriate

White	Chinese	Indian	Bangladeshi	Pakistan	Black African	Black Caribbean	Arabic	Other (please state)

I do not wish to give this information ☐

CHILDHOOD VACCINATIONS

This section should be completed if the form refers to a child.

Developmental Assessments: (Please enter dates)

8 Wks: ..... /..... /.....	8 Mths: ..... /..... /.....	2 Yrs: ..... /..... /.....	4Yrs : ..... /..... /.....

Vaccination/Immunisations: (Please enter dates)

1st Diptheria/Tetanus/Pertussis (DTP); Polio, Hib	..... /..... /.....		
2nd Diptheria/Tetanus/Pertussis (DTP); Polio, Hib	..... /..... /.....		
2nd Diptheria/Tetanus/Pertussis (DTP); Polio, Hib	..... /..... /.....		
Pneumococcal	..... /..... /.....	..... /..... /.....	..... /..... /.....
Meningitis C	..... /..... /.....	..... /..... /.....	..... /..... /.....
MMR Measles/Mumps/Rubella	..... /..... /.....		
Pre-School Booster: Diptheria/Tetanus/Pertussis (DTP); Polio	..... /..... /.....		
Pre-School Booster: Measles/Mumps/Rubella (2nd MMR)	..... /..... /.....		

BCG	..... /..... /.....	Measles	..... /..... /.....	Rubella	..... /..... /.....

OTHER IMMUNISATIONS – Please list below any other immunisations your child has had.

Please state which GP Surgery/Clinic immunisations were given

Do you have any supporting paperwork to confirm your child's immunisation history? **If "Yes" please supply with this completed form to enable copies to be taken.**	YES	No

Patient records are held on computer as well as paper. GP's are responsible for the confidentiality of these records. On occasions we share information from the patient records with the Health Authority, Primary Care Trust, Hospital and other NHS Specialists in the interest of patient care.

I agree to my son/daughters medical records being held under the above terms and I certify that the information I have provided is correct to the best of my current knowledge

Patient's Representative Signature..... Relationship to Patient.....

Date.....