## **AILSA SURGERY**

42 ADMIRAL STREET, GLASGOW, G41 1HU

## NEW PATIENT REGISTRATION (age under 16 yrs) To be completed by parent / guardian

To be completed by pa	arent	/ guaruian						
SURNAME:								
FIRST NAME:				TITLE:				
DATE OF BIRTH:		//	GENDER:	Male	e 🗆	Fem	nale $\square$	(tick box)
ETHNICITY:				(Th	nis is a	health	n board red	quirement)
Interpreter required?	YES		Language:					
<b>CONTACT DETAIL</b>	.S							
ADDRESS: Including flat no.								
POSTCODE:								
TELEPHONE NO:								
Who does this	Eg Mo	other / Father						
Are you happy to have messages left on this number?  YES NO								
MOBILE NO:								
	Are you happy to have messages left on this number?  YES NO							
Do you consent to allow the practice to send non- clinical information by SMS to the mobile number?				YES 🗆 NO 🗆				
SIBLINGS AT THIS ADDRESS:	Name:	Date of birth:						
Other adults living at home address:	Name:	Relationship to child:						
MEDICATION								
Is your child on any regular medication? Please list below								
DRUG NAME:		FREQUENCY						
ALLERGIES								
DRUG NAME:		Type of reaction – eg rash, muscle pain etc						

MEDICAL HISTORY							
Does your child have any of the following conditions?							
High blood pressure	YES 🗆	NO Epilepsy		YES NO			
Stroke / TIA	YES $\square$	ΝО □	Cancer		YES NO		
Heart Disease	YES $\square$	ΝО □	Asthma		YES NO		
Diabetes	YES $\square$	ΝО □	Do they use in	halers	YES NO		
OTHER DIAGNOS	OTHER DIAGNOSES & OPERATIONS						
Has your child had any serious illness, accident or operations, x-rays or similar tests?							
Please list below					APPROX DATE		
FAMILY HISTORY	<u> </u>						
Has a first de	egree rel	ative (parent	or sibling) suffere	d from t			
Disease:		Tie	ck box:		Mother/Father Brother/Sister		
Cancer: YE			NO □		Brother/Sister		
			YES NO D				
Stroke / TIA:		YES NO NO					
Diabetes:	YES 🗆 NO 🗆						
High Blood Pressure:		YES 🗆 NO 🗆					
Asthma:		yes [	□ NO □				
Other serious illness:							
<b>VACCINATIONS</b>							
Which vaccinations have your child had and when:							
Vaccination:	Date:		Vaccination:	Da	te:		

## **ETHNIC MONITORING**

NAN	1E:	D	ATE OF BIRTH:					
Ethn	ic Grou	ıp:						
A.	Whit	e						
		Scottish Other British Irish Any other white background (specify)						
В.	Mixe	d						
		Any mixed background (specify)						
C.	Asiar	Asian, Asian Scottish, Asian British						
		Indian Pakistani Bangladeshi Chinese Any other Asian background (specify)						
D.	Black	k, Black Scottish or Black British						
		Caribbean African Any other Black background (specify)						
E.	Othe	r ethnic background						
		Any other ethnic background (specify)						
F.	Othe	r						
		Prefer not to say  If you do not know your ethnicity, tick h	iere					