Newnham Walk Surgery - Health Information Questionnaire Aged 6 or under

Title	Surname	Forename	Date of Birth

Cambridge Address:

Tel (land line/mobile): Post Code:

Emergency contact name, relationship and contact number (in UK only):	Place of birth:
How long will you be staying in Cambridge:	**Today's date:**

Religion:	**First language:**	**School attended:**

Who has parental responsibility:

Sibling names:			

CHILDREN UNDER 6 YEARS OF AGE – AN IMMUNISATION ASSESSMENT APPOINTMENT MUST BE MADE AT THE TIME OF REGISTRATION FOR ALL CHILDREN AGED SIX AND BELOW.

Name:

Doctor's Initials:

PATIENT ETHNIC ORIGIN QUESTIONNAIRE

This questionnaire follows the recommendations of the Commission for Racial Equality and complies with the race Relations Act.

Please indicate your ethnic origin. This information is used purely for clinical use. It may also help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.
Choose ONE section from A to E, and then tick ONE box to indicate your background.

A White

	British
	Irish
	Any other white background:-

B Mixed

	White and Black Caribbean
	White and Black African
	White an Asian
	Any other mixed background please indicate which:-

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background please indicate which:-

D Black or Black British

	Caribbean
	African
	White and Asian
	Any other black background please indicate which:-

	Chinese
	Any other please indicate which:-

ethnic group

Confirmation of residence verified YES / NO Staff initials: Date: / /

Please turn overleaf…….

NAME

Date of Birth

NEW PATIENT IMMUNISATION FORM - CHILDREN AGED 6 YEARS OLD OR BELOW

	1st Vaccination Date	UK Or Overseas	2nd Vaccination Date	UK Or Overseas	3rd Vaccination Date	UK Or Overseas	4th Vaccination Date	UK Or Overseas	5th Vaccination Date
Diphtheria									
Tetanus									
Pertussis									
Polio									
Hib									
Meningitis C									
Pneumococcal									
MMR									
BCG									
Hepatitis B									

Summary Care Record – see attached details.

Would you like a SCR?
YES – no further action required
NO – you MUST complete the authority and hand it in with this form.

	Initials	Date
Fwd to…		
Notes to Dr		
Summary		
Scanned		

Hepatitis B status of mother Positive/Negative Please delete as appropriate.